

**A QUALITATIVE STUDY TO EXPLORE THE EXPERIENCE OF PSYCHIATRIC
STAFF WHO CARE FOR FREQUENT USERS OF INPATIENT SERVICES.**

By

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Abstract

A systematic search to identify service level interventions carried out on people admitted to an inpatient psychiatric hospital to assess the outcome measure of readmission. Thirteen relevant studies were identified, reporting six broad service level interventions. Preliminary findings suggest that inpatient interventions are effective in reducing readmission of 'revolving door patients' hospitalisation.

A presentation reporting the process of recruitment for a piece of research aiming to assist in enhancing support and develop interventions of young people with early psychosis. This was achieved using Joiners (2005) Interpersonal Psychological Theory of suicide behaviours to enable a greater understanding of why these people were more likely to attempt suicide compared to others.

A study aiming to explore the experiences of psychiatric staff working with people diagnosed with personality disorder. Six qualified staff from a female inpatient psychiatric ward were interviewed for a qualitative study, with transcribed data being analysed using Interpretive Phenomenological Analysis (Smith, 1996). Three superordinate themes emerged; struggling to treat in the absence of "illness," understanding the person behind the behaviour and the influence of control. Providing psychological reflective practice and formulation for hospital staff may enable a greater understanding of the patients' needs whilst in their care.

Acknowledgement

The writing of this thesis has been one of the most challenging pieces of work I have completed to date. I would like to pay gratitude to Dr Michael Larkin (ML) for supervising me throughout my thesis and providing me with valuable feedback and support. This has enabled me to become more confident in my own ability as a researcher and enabled me to gain greater insight into the application of psychology in applied settings. I would like to thank Dr Eleni Theodosi (ET), for agreeing to take me on as an honorary assistant psychologist and providing me with the opportunity to be part on an NHS multidisciplinary team. This has been invaluable for my final project and allowed me to reflect on how psychological input can be beneficial within the workplace. Finally, I would like to thank the hospital staff who took time out of their busy working day to participate in my research project. Without their openness and honesty this project would not have been possible.

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Overview

When accepted onto the MRes course, my primary objective was to gain a variety of skills that would enhance my suitability for further clinical training and research. I chose all three of my placements carefully, with specific objectives in mind to help me achieve this goal. The learning objectives that I perceived to be of importance were to expand on my research ability, to gain clinical experience in NHS settings and to conduct my first piece of qualitative research.

Placement one required me to conduct a systematic literature review on inpatient interventions, to gain a greater understanding of how readmission could be reduced on psychiatric wards. This enabled me to fulfil my first learning objective, as this method of research was not something I had had undertaken as an undergraduate. Furthermore, while researching the clinical training programs that were of interest to me, this reviewing process was an assignment requirement that I would be asked to complete. As I discuss in chapter one, this process highlighted the lack of research in this area, the poor methodology utilised and the limited range of interventions reported. This made the research challenging to synthesise and when feedback was provided, it highlighted that my writing, in parts was verbose. On reflection, I realised that this was due to my own insecurities of not knowing which parts were acceptable to omit. However, through the utilisation of feedback, I was able to become more concise with my writing and have become more confident in my writing of research from an academic as well as an NHS perspective.

The lack of interventions, that were seen to reduce readmission successfully, enhanced my understanding of why staff, working on an inpatient psychiatric ward, may have experienced difficulties working with this patient group. Through clinical supervision and feedback, I

have been able to gain a greater insight into how a perceived lack of interventions that work for this patient group, can make staff feel frustrated and helpless when their best efforts to keep these individuals from returning to hospital do not work. By gaining this awareness, I now attempt to use each encounter with staff (and clients) as a psychological intervention to increase their awareness of the positive achievements they can make with these individuals, which I believe will enhance working relationships. This placement has enabled me to become more familiar with the research within this area and provided me with an initial insight into the staff experience. This has inspired me to try to understand this experience in more detail, and provided a sound basis for my final project conducted in placement three.

My second placement was to recruit participants to investigate the moderators between suicidal desire and behaviour in young people with early psychosis. This was part of a clinical trainee's final year project and met my second learning objective through gaining some clinical experience in community settings. Throughout this placement I have learnt to appreciate how working in different NHS settings provides different challenges for clinical psychologists. Through reflection, I now have a greater understanding of the dynamics of 'power' within these different settings. I appreciate that whilst in a mental health hospital, clients may feel powerless in their recovery, contributing towards a barrier to treatment. When working in the community with service users, a more equal association can be established which can enhance engagement and relationships. I perceived this as a valuable insight going into my final placement, with the awareness of this barrier making me more focused on empowering the clients that I worked with whilst in hospital, to work on personal goals that could aid them in their own recovery.

My final research project enabled me to meet my third learning objective of conducting a qualitative piece of research. This piece of work aimed to gain a greater understanding of the

experience of hospital staff who worked with individuals diagnosed with personality disorder and were admitted to inpatient services. This required me to collect data from six qualified members of staff, using semi structured interviews that I had constructed. This was by far my biggest challenge in my academic career to date and initially felt quite overwhelming, when I started to analyse my first transcript of data. However, by receiving detailed feedback, I was able to grow in confidence in my ability to use this qualitative method and now feel that I can use this effectively when conducting research. Furthermore, I now appreciate how this method can enable a greater understanding of the lived experience and how this can help to inform clinical practice.

This masters has provided me with the opportunity to achieve all three of my objectives and has reconfirmed my desire to conduct research and practice in clinical settings. I have been able to expand my research ability, increase my clinical experience working within different NHS settings and broaden the range of research methods that I can apply to data. I believe that these new skills and experiences, in addition to those already obtained as an undergraduate, will strengthen my application for further clinical training and help me to obtain my goal to become a clinical psychologist.

Reflection on placement

Aims

- Conduct a systematic search of the literature on inpatient interventions focussing on reducing readmission to psychiatric hospital.
- Conduct staff interviews and behavioural observations on the male and female ward for a mapping project to examine staff and patient activity.
- Input and analyse data collected from behavioural observation with an aim to adapt staff resources according to demand and understand patient movement to provide interventions to increase positive ward activities.

The principal aim of my placement was to search for relevant literature on inpatient interventions aimed at reducing readmission of “revolving door” patients who are frequently readmitted shortly after discharge. Having limited clinical experience, I asked my supervisor if some of my placement objectives could be centred on the practical aspects of clinical work. I was fortunate to have the opportunity of being an assistant psychologist during this time, which allowed me to develop my research skills both academically and in applied settings at an NHS hospital. This enabled me to appreciate how my research could help to solve real problems experienced within the mental health service and how the two different approaches complimented each other through utilising previous research and identifying current practices on the ward.

My primary objective was to search and review the relevant literature. This was achieved through an in-depth examination of the literature in the area, identifying key words used by prominent authors and utilising these in my search criteria. This process allowed me to become more confident and efficient in how I searched for journals articles and helped me

become more familiar with research within this area, which will be beneficial for me when I continue to explore this subject further for my project.

I found that synthesising the data for my review was challenging, with limited research being made available, incorporating a variety of interventions and poor methodology. However, due to the methodological weaknesses in the literature I had the opportunity to improve my critical evaluation skills and gain a greater understanding for the restrictions and ethical issues when conducting clinical research. This highlighted the implications for more robust randomised controlled trials in future research.

The next set of placement goals centred on conducting a mapping exercise to determine how resources were used on both the male and female wards. To achieve this, a behavioural observation technique was used to assess the current activity of both staff and patients. I was asked to assist my supervisor in generating a coded schedule for the staff and patients. This made me appreciate how much I had learnt about activity on the ward and enabled me to generate categories prior to the observation that eliminated bias and utilised a more systematic approach.

Using the coded schedule, 2 sets of 24 hour observations were carried out by 3 researchers, on both wards. I was asked to undertake 2 shifts of 8 hours, using time sampling of 15 minutes, to identify a baseline for the ward routine. I was not familiar to the patients on the male ward and became aware that I may have potentially changed their behaviour due to them being inquisitive about me. I now appreciate the advantages of familiarisation with the patients prior to observation to allow for habituation of the group when I am present.

Initially, one of my objectives was to input and analyse the data collected from the behavioural observations on the ward. Unfortunately, due to the observation being conducted

on my last two days on placement, I was unable to achieve this. However, I now have a better understanding of the length of time it takes to arrange and finalise such observations and will ensure that I leave myself more time in future research.

My final placement goal required me to help generate and conduct staff interviews about self-harm, violent behaviour and suicide with an aim to identify areas where staff were confident or required more training in their role. During the first interview, I sensed the interviewee felt uneasy about what would happen to the data collected. I researched different techniques and learnt to appreciate the importance of reassuring the interviewee of anonymity to improve rapport. I feel that this has been beneficial both to this piece of research and also enabled me to build a rapport for when I conduct further staff interviews for my project.

The staff interviews gave me insight into the difficulties of working with patients who had personality disorder (PD) and the difficulties staff experienced when trying to help support them. This highlighted the potential implications of the project I will complete, alongside a trainee clinical psychologist next year, with qualitative interviews enabling a greater understanding of the experience of PD from both a staff and patient perspective.

Additionally, this has informed the write up of one of my placement activities of conducting a systematic literature review of inpatient interventions. This piece of work, presented in the next section of this thesis, aims to produce a comprehensive summary of the current literature that target the reduction of readmissions in psychiatric hospitals. This approach, through assessing the outcome measures of readmission, is hoped to gain a greater knowledge of what interventions could be beneficial for staff to implement on the ward when helping these individuals who are frequently readmitted.

CHAPTER 1:

**INPATIENT INTERVENTIONS TO REDUCE READMISSIONS IN PSYCHIATRIC
HOSPITAL: A SYSTEMATIC REVIEW**

Abstract

Background

Up to 80% of total psychiatric inpatient resources have been reported to be consumed by so called ‘revolving door patients’ who are frequently readmitted shortly after discharge. At present, literature is emerging on interventions for use during inpatient admission aiming to assist in preventing future hospitalisation.

Aims

To evaluate the effectiveness of service level interventions provided in acute psychiatric settings designed to reduce readmission.

Method

A systematic search was conducted to identify service level interventions carried out on people who were inpatients admitted to a psychiatric hospital. The aim was to assess the outcome measure of readmission, using a defined inclusion and exclusion criteria.

Results

Thirteen relevant studies were identified, reporting six broad service level interventions. Effective inpatient interventions found to significantly reduce readmission at a service level were; lengthier stay in hospital, multiple component strategies, designated key workers provided at pre and post discharge and offering relapse planning.

Conclusion

Preliminary findings suggest that inpatient interventions are effective in reducing readmission of ‘revolving door patients’ hospitalisation. Future research using improved methodology,

homogenous interventions and larger samples would enable an evidence base to be further developed and help to determine effective clinical improvements using action research.

Introduction

Over the past six decades, mental health services have moved away from a focus on treating ill health in institutional settings and instead have focused on promoting independence, prevention and support for self-care whilst remaining in the community (Mental Health Commissioning Strategy, 2010). This has seen inpatient services shifting, due to the deinstitutionalisation of mental health services, from a place of long term confinement to a short stay containment environment for people in crisis, with additional help being provided in the community following discharge (Lamb & Bachrach, 2001). However, there still remain some individuals with severe psychological illness that continue to require psychiatric hospitalisation. These individuals, who comprise a small proportion of all service users requiring hospital treatment, have been found to utilise a disproportionate quantity of psychiatric inpatient facilities (Roick et al., 2004). It has been reported that these people sometimes referred to as ‘revolving door patients,’ but more appropriately recognised as frequent attenders, comprise up to 20% of individuals with severe and enduring mental illness, but consume 60-80% of total inpatient resources (Junghan & Brenner, 2004).

These half a million people in the UK (Tadros et al., 2013) who are frequent attenders have been estimated to cost the NHS £2.3 billion annually (Syed & Congdon, 2007). Government policy, aiming to reduce this high utilisation of services, has reduced the number of mental health beds from 32,753 in 2003 to 26,928 in 2008, displaying a 17% reduction (RCP, 2009). Additionally, strategies have set a benchmark to reduce these services further, with community based mental health care being viewed as an improved method of care for some

patients (Mental Health and the Productivity Challenge, 2010). This has been supported by research, reporting negative outcomes of greater employment difficulties, diminished levels of functioning and inferior social relationships (Bruffaerts, Sabbe & Demyttenaere, 2004) for people who are frequently in need of hospitalisation. Additionally, frequent attenders have been seen to have a negative impact on hospital staff, who report feelings of frustration and a sense of helplessness, when best efforts to improve people's time spent in the community are found to have failed (Reid et al., 1999). As readmission would be seen as a detrimental cost to the health service, quality of life for the individual and staff morale, it is important to establish the effectiveness of service level approaches that attempt to target this problem.

A large amount of research in community setting has provided elaborate, cost effective, evidence based models which include early intervention services (Singh & Fisher, 2004) and assertive outreach (Salyers & Tsemberis, 2007). However, research investigating models to improve people's ability to cope whilst in inpatient care, has been slower to be undertaken, even though it is recognised that this service utilises greater amounts of funding (Mental Health Commission, 2010). This safe hospital environment, whilst having the challenge of intervening within a limited time frame, could provide a valuable opportunity to educate people and establish a greater rapport with the mental health service (Siefert, 2012).

A broader literature exists which focuses on reducing hospital admission generally (Thornicroft et al., 2013; Burns et al., 2013), and specifically the use of compulsory detention. Previous research has demonstrated that inpatient interventions can be effective in reducing readmission in a variety of different ways. Providing a longer initial length of stay for individuals diagnosed with schizophrenia (Appleby, Desai, Luchins, Gibbons & Hedeker, 1993) and providing a brief planned admission for people diagnosed with borderline personality (Kessel, Lambie & Stewart, 2002) have both been reported to be effective,

suggesting that the diagnosis may have an impact on the inpatient intervention implemented. Furthermore, educating service users of their mental illness (De Groot, Lloyd & King, 2003) and providing consistency of care both during a hospital stay (Thambyrajah, Hendriks & Mehendran, 2007) and following discharge (Juven-Wetzler, Cwikel-Harzany, Abudy & Zohar, 2012) would highlight that staff interaction can have a positive impact on reducing readmission. Previous research would suggest that numerous factors could be beneficial to review in more detail. In this paper, our aim was to systematically review the effectiveness of interventions provided in psychiatric hospitals in order to reduce *readmission*.

Method

Search strategy

A systematic search of literature published between January 1993 May 2013, was carried out using the electronic databases; PsycINFO, Embase, CINAHL, Medline and Web of Science. The searches were limited to participants aged 18 to 65 years due to this being the largest age range of mental health service users. Additionally papers were included that focused on what could be achieved at a service-level, during a relatively short acute stay. Therefore, psychotherapies were excluded due to these interventions exceeding the length of time available whilst in hospital. Papers were included that clearly reported an outcome of reducing readmission. The exclusion of forensic settings, adolescents, organic mental health disorders, substance abuse, homelessness and learning disabilities were omitted from the search criteria (see table 1) as these were found to have a range of different needs that would require a variety of further interventions in addition to mental health difficulties. Changes were made to accommodate the search criteria for each data base utilised. A flow chart of the PsycINFO search criteria is displayed in figure 1. This provides all key search areas of the interventions used which included “educate “or prevent “or “reduce “or “train” or “outreach” or “discharge planning” or “reintegration” adjacent to “service” or “intervention” or “program” or “approach” or “model” or “aftercare” or “strategy”. Reference lists of the papers to be included were screened for additional relevant articles that met the inclusion criteria. No restriction of language was applied. After initial scoping searches it was recognised that no single field of intervention research in this area had grown sufficiently far to justify being reviewed in its own right so a broad scope of the literature was included in the review. Interventions that were included were determined on an ability to reduce readmission rate after an admission to an inpatient ward.

Table 1: Applied inclusion and exclusion criteria

Articles for Inclusion	Population inclusive of mental health inpatients aged 18-65
	Outcome of readmission rates reported
	Interventions conducted on a psychiatric ward that were successful in reducing future readmissions
Articles for exclusion	Population from exclusively forensic setting
	With exclusively adolescents (<18) or older people (>65)
	With exclusively organic mental disorders (Alzheimer's disease or Dementia)
	With exclusively substance abuse
	People specified as homeless
	People specified with learning disabilities
	Interventions that primarily involved symptom-focused therapies, such as cognitive behavioural therapy. These were excluded as these interventions could not be completed in the time frame of an inpatient admission

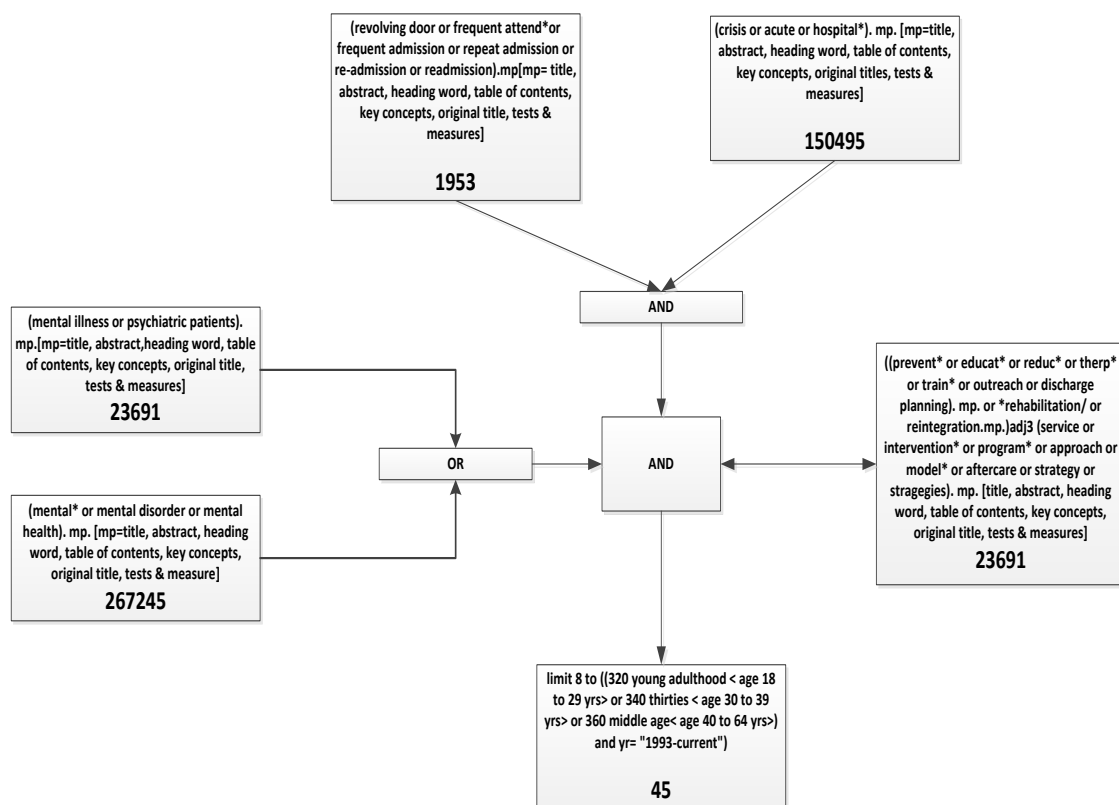


Figure 1: Search strategy utilised for PsycINFO

Search process

The database search generated 618 potentially relevant studies, of which 168 were duplicates. After titles and abstracts were checked against the inclusion and exclusion criteria, 419 papers were removed. Thirty-two studies were reviewed in full text, with 19 studies being excluded for the following reasons: outpatient $n = 10$, planned intervention with no evaluation provided $n = 7$, no details of readmission rates $n=2$. This can be seen in figure 2. Thirteen studies met the inclusion criteria displayed in table 1 for the final literature review. A summary table extracting data from the 13 studies included for review was developed and is displayed in table 2 by year of publication. The table headings are broken down into three different sections for each study. The first details the methodology of the studies and displays the experimental design, mental illness types of participants, sample size, name of the intervention utilised and the control group that the intervention was compared to. The second section refers to the interventions for each study and presents the details of each intervention component and how the intervention outcome measures were determined. The final section provides the measures and includes detail of the length of follow-up, what outcome measures were reported and the quality of design when using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers (Kmet et al., 2004).



Figure 2: Stepwise literature review procedure

Table 2: Summary of key measurement characteristics of psychiatric inpatient interventions.

First Author	Year	Location of study	Methodology					Intervention details		Measures		
			Design	Mental illness	Sample size	Intervention	Control	Intervention components	Intervention outcome	Length of follow-up period	Outcome measure	Design quality score (0-1)
Appleby, L.	1993	USA	Case series	Schizophrenia	1500	LOS	N/A	Duration of initial admission to psychiatric hospital	Length of stay sig related to each time to relapse.	30 days and 18 months	Time in the community before relapse	0.50
Dilonardo, J.D.	1998	USA	RCT	Various	57	SIH	TAU	Prescheduled four hospital admissions, each lasting nine to eleven days over a two year period, with intervals of 11-13 weeks between hospitalisation. Community ward meetings Meetings with psychiatrist and primary nurse Group therapy Plans for follow-up care Therapeutic and recreational activities (on and off ward)	Higher self-esteem, no sig difference between groups on readmission or days in hospital	24 months	Reduce hospitalisation days in hospital and enhance self esteem	0.71
Kemp, R.	1998	UK	RCT	Psychotic disorder	74	CT	NSC	Compliance therapy Illness history review Ambivalence towards treatment addressed Dealing with stigma	Sig difference for compliance, insight, global functioning, readmission. No sig difference time spent in hospital	18 months	Compliance/ insight/drug attitude/global functioning/symptoms/ readmission and days in hospital	0.79
Wickizer, T.M.	1998	USA	Case series	Various	2443	UM	N/A	Duration of initial admission to psychiatric hospital	Each day LOS reduced, adjusted odds of readmission increased by 3.1% (p = 0.004)	60 days	Readmission rates	0.61
Kessel, K.V.	2002	New Zealand	Cohort	BPD	21	BPA	TAU	Briefed planned admission approach Capped length of stay on admission Specified goals negotiate by patient and hospital staff prior to admission Pathway for admission through community services Explicit management plan Clear rationale provided for using intervention to patient Consequences for behaviour contradictory to therapeutic goals Activation of community services	Sig reduction in the number of days hospitalisation in BPD group, no sig difference in readmission	60 months	Reduce hospitalisation and days in hospital	0.50
De Groot, L.	2003	Australia	Cohort	Psychotic disorder	54	FP	TAU	Education and information about psychosis Early warning signs Treatment and medication Behavioural strategies Information regarding community resources and mental health service Balancing family needs Career perspectives Exploring family concerns Providing support Facilitating problem solving	No difference between groups of readmission or duration no impact on level of care and increased knowledge	N.R.	Readmission rates, days in hospital experience of caregiver and increased knowledge	0.54
Ho-Wan Chan, S.	2007	Hong Kong	RCT	Schizophrenia	81	TRIP	WOT	Mental Health education Emotion management Introduction to schizophrenia Rehabilitation resources for residential and family services Rehabilitation resources for vocational and social services Medication management and compliance Relapse prevention plan development Symptom management Healthy diet and lifestyle Stress management	Odds of relapse ratio was 1.75 times greater for occupational therapy compared to TRIP, sig better health and insight	12 months	Greater insight and health and lower relapse rate	0.75

Thambyrajah, V.	2007	Singapore	Cohort (before and after)	Various	88	BCM	N/A	Broker model case management Assessing patients Preparing care plans Linking patients to community services Providing psychoeducation Providing counselling Case management by telephone after discharge	Sig reduction in admission rate and hospital length of stay and improved CGI scores	12 months	Readmission rates, days in hospital and scores on Clinical Global Impression scale	0.46
Lang, T.P.	2009	USA	Cohort	Various	184	MIPA	TAU	Psychological testing Occupational therapy Chemical dependence evaluations Smoking cessation group Diet group Family meetings Relapse planning Follow-up visits Length of stay 8+ days	Lower odds of readmission within 30 days for MIPA ($P<.03$)	30 days	Readmission rates	0.50
Petrie, R.X.A.	2009	UK	Cohort (before and after)	Various	35	RA	N/A	Rehabilitation team managing care, planning and integrating inpatient to outpatient services	Sig reduction in readmission, days in hospital and use of Mental Health Act	24 months	Readmission, days in hospital and number of uses of Mental Health Act	0.50
Vasudeva, S.	2009	India	Cohort (retrospective)	Various	516	FHA	LOS	Duration of initial admission to psychiatric hospital	Sig difference between 3 groups: brief first hospital stay (1-7 days) more likely to get readmitted than >2 weeks	42 months	Readmission rate	0.54
Juven-Wetzler, A.	2012	Israel	Cohort (before and after)	Various	35	COC	SCP	Psychiatric, psychological, nursing and social rehabilitation care continued by the same personnel after discharge. Discharge planning Adherence to medication Accompanied to rehabilitation institution by staff on initial meeting Phone ward psychiatrist instead of attending emergency room	Fewer admission, sig decrease in total no of hospital days comparing 1 year period before/after	30 days, 12 months and 18 months	Days in hospital and rehospitalisation	0.57
Stewart, M.W.	2012	New Zealand	Cohort	Various	292	DCC	TAU	Care coordinators provided consistent point of contact for patient Single point of contact for family and community resources Community services engaged throughout admission to hospital Facilitate post-discharge reintegration into community	No difference in length of stay, sig better clinical outcome and sig fewer readmission ($p<0.04$)	30 days	Service delivery, clinical outcomes, days in hospital and readmission	0.71

Key:

RCT, randomised control trial; *QES* quasi-experimental study; *BPD* personality disorder; *LOS*, length of stay (days); *FP*, family psychoeducation; *TAU*, treatment as usual; *SIH*, scheduled intermittent hospitalisation, *TRIP*, transforming relapse and instilling prosperity; *WOT*, ward occupational therapy; *COC*, continuation of care; *SCP*, standard care program; *CT*, compliance therapy; *SP*, supportive counselling; *BPA*, brief planned admission, *MIPA*, multifaceted inpatient psychiatry approach, *RA*, rehabilitation admission; *DCC*, designated care coordinator; *RAID*, rapid assessment interface and discharge; *BCM*, broker case management; *FHA*, first hospital admission; *UM*, utilise management; *N.R.*, not reported.

Summary of the interventions included

Thirteen differing interventions were reported within inpatient psychiatric hospitals (please refer to table 2 for intervention components), with one of these being in the private health care domain (Wickizer & Lessler, 1998). Of these thirteen interventions that aimed to reduce readmission, three procedures focused on the initial length of stay in hospital (Appleby et al., 1993; Vasudeva et al., 2009; Wickizer & Lessler, 1998), one reported on brief interventions with multiple components (Lang et al., 2009), four focused on consistency of care provided for patients, two during inpatient stay (Stewart et al., 2011; Thambyrajah et al., 2007) and two after discharge (Juven-Wetzler et al., 2011; Petrie & Mountain, 2009), three utilised relapse planning (Ho-Wan Chan et al., 2007, de Groot et al., 2003; Kemp et al., 1998) and two provided intermittent planning of future hospital admissions (Dilonardo et al., 1998; Kessel et al., 2002).

Quality assessment

The internal validity of the 13 papers that met the inclusion criteria were examined by two independent raters, using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers (Kmet, Lee & Cook, 2004). This quality assessment tool was used as it enabled the quality of the diverse study designs included in the review to be assessed simultaneously. This quality assessment reported an interrater reliability of .76 (SD .16) and helped in assisting in exploring the variation across studies and in the synthesis of the research findings (Kmet, Lee & Cook, 2004). This 14 item tool enabled quality from a variety of study design to be evaluated for eligibility for the inclusion of the review (please refer to appendix 1). Every study was measured using a rating scale of yes, no, partial or not

applicable to the study design, with a maximum possible quality score of 1 (see table 2 for total quality scores). No studies were excluded based on this assessment tool.

Quality of the included studies

The 13 psychiatric interventions included in the review were found to be predominantly in the lower quality range when assessed using Standard Quality Assessment Criteria for Evaluating Primary Research Papers (Kmet et al., 2004). Eight studies scored in the low quality range, three in the moderate and two in the higher quality range (see table 2 for rating scores). All studies enabled a detailed assessment of the intervention, by providing a well-described study design. Additionally, analytic methods and detail of results were all rated highly across all studies. Blinding of the investigator was only reported in two studies and only one of the three RCT reported the method of allocation utilised.

Those studies that were rated as low on the quality assessment displayed a variety of different limitations. Kessel and colleagues (2002) used a small sample size (n=10), did not describe the study design in detail and lacked reporting clinical outcome measures other than suicide rate. Vasudeva, Kumar and Sekhar (2009) utilised a retrospective study, provided limited information about the characteristics of the participants and did not record previous admissions. Lang and colleagues (2009) did not utilise random allocation to groups, and the outcome measures reported could have been effected by confounding variables due to procedural changes during the duration of the study. Degroot, Lloyd and King (2003) were also unable to randomly allocate participants, recruited a small sample size making the study underpowered (n=29) and used numerous facilitators throughout the intervention which may have confounded the results. Kemp Kirov, Everitt, Hayward and David, (1998) also didn't control for confounding variables by using indirect measures based on information from

multiple sources, blinding was not utilised for the experimenter and a small sample was recruited (n=74) making the study underpowered. Petrie and Mountain (2009) recruited participants using a small sample of case notes (n=35), retrospectively. Of this small sample a large standard deviation was reported indicating that the admissions studied were highly variable. Some participants in this study spent time on a waiting list which may have affected the data. Thambyrajah and colleagues (2007) rated the lowest score of the studies included, with the method of selection being retrospective, outcome measures limited and analytical measures not justified. Finally, of those rated on the lower range, Appleby, et al., (1993) did not control for confounding variables when measuring length of stay as this was not randomly allocated to patients within the hospital and was not matched across hospital. An absence of clinical ratings being reported reduced the rating for outcome measures.

Of the three studies rated as moderate, Wickizer and Lessler (1998) collected data from a database and could not ascertain if participants had complied with the experimental condition. Due to this, the validity of the length of stay reported was not robust. Juven-Wetzer and colleagues (2011) study used only a small sample of participants (n=35) and due to being a retrospective study no blinding was used. Finally, of those rated as moderate, Dilionardo and colleagues (1998) did not describe how participants (n=57) were randomly allocated in detail and no blinding was utilised.

Two high quality studies were found to have minor limitations. No blinding was used when assessing the interventions by Ho-Wan Chan, Lee and Wai-Mei (2007) and the sample size (n=57) was too small to detect significant difference in improvement. Stewart and colleagues (2012), were unable to randomly allocate participants to conditions due to the ward organisation of the intervention but did score full ratings for all other components.

Characteristics of included studies

The studies included (table 2) were predominantly conducted in developed westernised countries (United Kingdom, United States of America, Australia, New Zealand, Singapore, Israel and Hong Kong), with one study being carried out in India. The sample sizes ranged from ($n=21$) (Kessell, Lambie & Stewart, 2002) to ($n= 2443$) (Wickizer & Lessler, 1998) with a mean number of participants across all studies of 769. A variety of study designs were included; three were randomised controlled trials (Dilonardo et al., 1998, Ho-Wan Chan, Wing-Kin Lee & Wai-Mei Chan, 2007; Kemp, et al., 1998), three non-randomised quasi-experimental studies (de Groot, Lloyd & King, 2003, Lang, Rohrer & Rioux, 2009; Stewart, Wilson, Bergquist & Thoburn, 2012), four before/after comparison studies (Juven-Wetzler, et al., 2012; Kessel et al., 2002, Petrie & Mountain, 2009; Thambyrajah, Hendriks & Mehendran, 2007) and three case series (Appleby, et al., 1993; Vasudeva, Kumar & Sekhar, 2009; Wickizer & Lessler, 1998). Four of the included studies restricted their samples to schizophrenia or psychotic disorder, whilst the remainder comprised of a range of mental illnesses.

Results

Length of stay

Three pieces of research investigated the relationship between the duration of an initial inpatient hospital stay as an intervention and the outcome measures of future readmission rates. The findings from two of these studies suggest that a length of initial stay of less than 14 days has a detrimental effect on readmission rates for individuals with schizophrenia, with these people returning within 30 days after discharge (Appleby et al., 1993; Vasudeva et al., 2009). This difference in readmission was most prominent at 6 months after discharge, but

presented little variance after 1 year (Appleby et al., 1993; Vasudeva et al., 2009). In all three studies, individuals with a diagnosis of schizophrenia were found to have the highest readmission rate after a short stay in hospital, with this being measured over 30 days (Appleby et al., 1993), 60 days (Vasudeva et al., 2009) or three-and-a-half year period (Wickizer & Lessler, 1998). However, when considering the effects of length of stay in hospital on a range of mental illnesses, the research would propose that for each day of initial stay that is restricted, the possibility of relapse increases by 3.1%, therefore on a continuum rather than the 14 days seen as critical for patients with schizophrenia (Wickizer & Lessler, 1998). Therefore, the findings would tentatively indicate that a reduction in hospital days has a detrimental impact across a range of mental illnesses, with patients who have schizophrenia being most vulnerable to be readmitted.

Brief interventions

The findings of Lang et al. (2009) would question the importance of a lengthier period of initial crisis hospitalisation, reporting similar significant reductions in hospital admissions as an outcome measure, after a 5-7 day hospital intervention using a biopsychosocial approach when compared to treatment as usual. This multifaceted intervention included psychological testing, occupational therapy, chemical dependency evaluation, family meetings, relapse prevention, follow-up visits (please refer to table 2 for all components). The findings from this research would indicate that numerous components, when combined together, could have a collective impact on reducing relapse rates (30 day period), over a shorter hospital stay. These findings differ from Appleby et al. (1993) and Vasudeva et al. (2009) by suggesting that it is not the length of stay that is of importance but what interventions are implemented during this period. However, this could be due to a variety of mental illnesses being included in this intervention, supporting Wickizer and Lessler (1998) that required length of stay

differs across diagnosis. Additionally, the diagnosis provided does not reveal the purpose of the stay, with different interventions potentially being effective, depending on the reason for admission (risk or delusional state). Furthermore, as there are ten components to the intervention, it is difficult to determine which specific aspect or combination may have caused the reduction in readmission rate. Future research investigating these factors individually would be beneficial to determine this.

Relapse planning

Three studies focused on inpatient interventions that aimed to reduce relapse rates using family psychoeducation and 'Transforming Relapse and Instilling Prosperity (TRIP).' The TRIP programme aimed to reduce non-compliance of medication and relapse rate by increasing insight of psychotic symptoms and increasing an awareness of health. The findings would suggest that providing psychoeducation about the illness has a greater influence on reducing the outcome measure of readmission when focused on the individual (Ho-Wan Chan et al., 2007; Kemp et al., 1998), rather than the family alone (de Groot et al., 2003).

Furthermore, two of the studies with an outcome measure of improving insight of the illness, suggest this to be of importance, with those found to have a greater awareness of symptoms, treatment and social consequences of mental illness, displaying significantly reduced readmission rates at 12 (Ho-Wan Chan et al., 2007) and 18 months (Kemp et al., 1998).

Incorporating motivational interviewing skills and cognitive approaches to reduce relapse of psychotic symptoms would seem to have the greatest effect, when compared to increasing awareness of illness. However, as the studies differ in their comparators, it is difficult to evaluate these accurately.

Consistency of care during hospital stay

Two studies focused on the impact of having designated key workers on an inpatient ward as an intervention with an outcome measure of readmission rates. Both of these studies reported a significant reduction in readmission rates at 30 days, 3 months (Stewart et al., 2012) and 1 year after discharge (Thambyrajah et al., 2007). The findings of both studies suggest that a consistent point of contact is beneficial for individuals in hospital, with this being seen to improve delivery of services through regular discharge planning, enhancing communication and accessibility with community services and improving clinical outcomes (Stewart et al., 2012; Thambyrajah et al., 2007). The preliminary findings would suggest that a small change in staff utilisation could enable the opportunity for enhanced interaction between staff and people in hospital, with this having a positive effect on readmission rates at little additional cost.

Consistency of care following discharge

Two studies focused on the effect of providing continuation of care after discharge as an intervention. Enhancing the connection between inpatient stay and community services using the same treatment team had a positive effect on the outcome measure of reducing readmission rates at 18 months (Juven-Wetzler et al., 2012) and 2 years (Petrie & Mountain, 2009). The results indicate that a greater rapport between staff and people in hospital increases adherence and reduces relapse. This was associated with faster recognition of symptoms allowing for rapid treatment and a greater understanding of previous barriers to engage with community services (Juven-Wetzler et al., 2012; Petrie & Mountain, 2009). This would support the findings of the key worker interventions that a consistent point of contact has a positive effect on readmission (Stewart et al., 2012; Thambyrajah et al., 2007) and also

relapse planning interventions that a greater awareness of symptoms is advantageous (Ho-Wan Chan et al., 2007; Kemp et al., 1998), but also indicate that an additional service that utilises the same treatment team after discharge could provide further support. However, as there are only two studies, that both employ 'pre v post' design, the possible influence of regression to the mean in readmission rates is problematic.

Intermittent planning of hospital stay

Two studies concentrated on an intermittent planned stay in hospital as an intervention, one with people with borderline personality disorder (BPD) (Kessel et al., 2002) and the other with individuals predominantly diagnosed with schizophrenia (Dilonardo et al., 1998).

Intermittent planning was found to reduce the outcome measure of readmissions more than traditional access to hospital admission, but differences were not reported as statistically significant. However, these results would maintain this strategy as an effective approach, with an introduction to intermittent planning not enhancing the 'revolving door' pattern, therefore suggesting that shortening admission when admissions are planned, does not lead to discharge occurring prematurely. This intervention reported an outcome of enhanced levels of self-esteem, reduced negative emotions and decreased complaints of physical symptoms (Dilonardo et al., 1998), with people reporting a greater sense of empowerment when being in control of their own treatment. Furthermore, staff morale was found to be increased using this strategy, with treatment being able to be planned prior to admission of each individual and smaller more realistic goals being set in advance (Dilonardo et al., 1998). People with BPD could additionally benefit from a shorter length of stay, with a 75% reduction per year being reported (Kessel et al., 2002). Therefore, this strategy could improve patient care by enabling individuals to increase their ability to cope with their illness once discharged from hospital. This could be achieved by providing support and a safe haven through intermittent

hospitalisation but without disrupting the individual's life like a traditional longer admission may do. This relationship was not found in individuals with schizophrenia, supporting findings that these people may benefit from a longer stay in hospital (Appleby et al., 1993; Vasudeva et al., 2009). Nevertheless, these findings would indicate that whilst an inpatient stay would still be viewed as important to individuals with poor mental health, a balance between emergency and scheduled visits could improve subjective wellbeing. This strategy would be seen to utilise hospital beds more efficiently, reduce the disruption and perceived failure of the individual through active participation, and prevent some crisis due to easier access to services through planned visits. Nevertheless, intermittent planning would not be seen as an effective intervention for reducing readmission overall.

Discussion

Thirteen studies conducted over the past two decades, assessed a heterogeneous group of interventions that incorporated six broad interventions. The authors of two of the studies reported a non-significant difference in readmission rates when providing intermittent planned stay in hospital, but did report that individuals with BPD reduced their length of stay significantly. The authors in ten of the thirteen studies reported a significant effect in reducing readmission. The preliminary findings would suggest that psychiatric readmission can be reduced through a variety of inpatient interventions, suggesting that there is potential to reduce cost to the health service, improve quality of life for the individual and enhance staff morale.

The length of stay for individuals with mental illness would be seen to be of importance, with those diagnosed with schizophrenia but discharged within 14 days of initial stay, being most at risk of readmission. However, as antipsychotic medication has been reported to improve

service users psychotic symptoms in the first two weeks of treatment (Agid, Kapur, Arenovich & Zipursky, 2003), this critical period could be due to how long symptoms take to stabilise rather than the length of stay in hospital. Nevertheless, whilst medication is taking effect, it could be beneficial, during this period, to implement inpatient interventions that could reduce the risk of further hospitalisation. It could be theorised that a reason for readmission is due to a lack of coherence between the transitions from hospital to community services, with time spent in the community being extended, when continuity of care throughout a hospital stay and subsequently after discharge is provided. This relationship between services and service users, when reviewing all the included literature, would suggest that improving liaisons between inpatient and community services could help to reduce future readmission.

It might be hypothesised that the requirements of continuation of care when in psychiatric hospital could differ depending on diagnosis, with BPD having different needs compared to individuals with schizophrenia. Whilst continuation of care would be found to be important, the length of time that this is provided in hospital may vary across these two illnesses. It is possible that attachment styles may influence this process, with individuals with schizophrenia being associated with avoidant attachment (Berry, Barrowclough & Styles, 2008). This could provide a further explanation of why a hospital stay of 14 days or more is beneficial, with these people being more distressed and needing longer to establish a good relationship to enable liaison with community services to take place. In contrast, individuals with BPD may benefit from a scheduled intermittent stay due to an insecure attachment style (Fossati, 2012). This could be advantageous due to a shorter length of stay decreasing dependency on key workers and making it easier for these individuals to take responsibility for their own behaviour when discharged into the community (Fossati, 2012). Therefore,

providing individuals with a continuation of care may be due to the quality of the relationships established, rather than the quantity of days hospitalised.

Whilst the preliminary findings of inpatient interventions are promising, the results would highlight that there is limited research published within this area, with only thirteen studies identified. In view of the limited research available, studies with a lower level of evidence (case series and before/after studies) were included. Whilst this enhanced the range of interventions incorporated, it also decreased the level of certainty of the findings, with four of the thirteen studies potentially inflating the impact of the intervention group due to regression towards the mean. Furthermore, no two studies measured the same intervention components and because of such clinical heterogeneity, a meta-analysis of interventions could not be conducted, demonstrating a requirement for replication of interventions using improved methodology.

The studies included in the review predominantly utilised small samples and were conducted in a variety of countries, making it difficult to ascertain the community service impact due to different funding and organisational structure of other health care systems. Furthermore, a diverse number of control groups provided different baselines to assess outcomes across studies. A further concern was heterogeneity of the psychiatric illnesses included. Different problems associated with readmission may differ across mental illnesses, with the same inpatient intervention not being effective in meeting the needs of all patients in a heterogeneous sample.

Overall, providing inpatient interventions for frequent attenders with mental illness would reduce future readmission. To further this understanding, in the long term, future research should utilise randomised controlled trials, using larger convenient sampling across hospitals

that provide similar services. Comparison groups and baseline measures should be standardised using a homogeneous population that measures the same intervention and timings of outcome measures. Whilst there is information available on inpatient interventions for those individuals with schizophrenia, there is limited research currently accessible on how interventions can be utilised for those with BPD. As a short term goal, exploratory research, using qualitative methods, should investigate the experience of both inpatient staff and individuals diagnosed with BPD to gain a greater understanding of the attachment dynamics and the effect this may have on the delivery of meaningful effective interventions. This could help in establishing a common framework that could be useful in facilitating communication between people with BPD and hospital staff and may help in the integration of different interventions based on a coherent view of attachment styles of these individuals.

At present, a tentative recommendation for practice would support providing a lengthier hospital stay of fourteen days or more for people with schizophrenia and providing continuity of care throughout inpatient stay and post discharge. Additionally, providing relapse planning whilst hospitalised, would be found to increase insight of the individuals mental health and awareness of symptoms, with improved adherence to medication reducing future relapses. Moving forward, action research could utilise these findings, with an aim to improve practice and strategies further within psychiatric hospitals.

CHAPTER 2:

**INVESTIGATING THE MODERATORS BETWEEN DESIRE AND BEHAVIOUR IN
YOUNG PEOPLE WITH EARLY PSYCHOSIS**

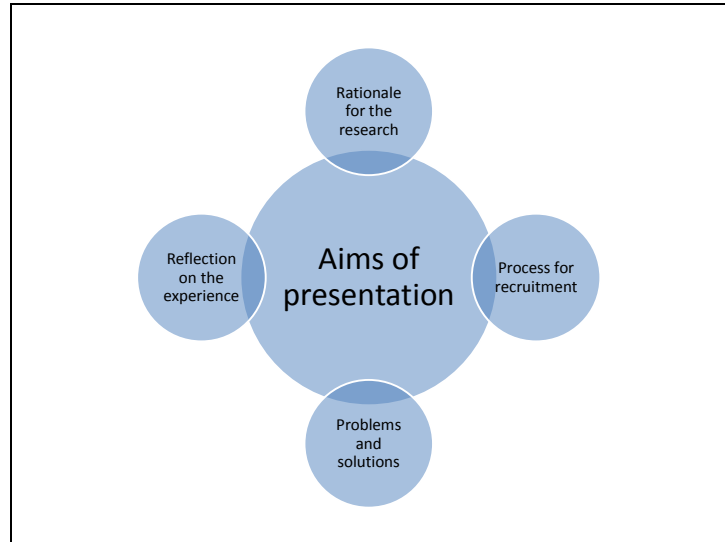
Introduction

Investigating the Moderators between Suicidal Desire and Behaviour in Young People with Early Psychosis

Sarah Berger

For my second placement, I worked within Early Intervention Services (EIS) investigating the moderators between suicidal desire and behaviour in young people with psychosis. EIS offers a service to young people aged 14-35 years who have had a first episode of psychosis or have had psychosis that has not been treated for less than a year's duration. This service is offered for a period of three years and aims to support and treat young people to understand psychosis and support them with coping strategies, recovery and any aspirations that they may have. Staff provide a variety of intervention which are specific to helping each young person in their recovery and aim to reduce the impact of psychosis and reduce the risk of hospital admission (Power, 2010). This service is of importance, due to the early years of psychosis being of high risk to suicide, with one person in a hundred committing suicide each year for the first five years after they have made contact with service. After an acute psychotic episode has ended approximately 15% of young people will continue to have a high level of suicidal thoughts for a further 18 months (Power, 2010). However, suicides can be avoided and EIS are uniquely placed to prevent this from happening (Appleby, Haw & Kapur 2006).

Even after their acute psychotic episode has abated, about 15% of people will continue to experience high levels of suicidality for 18 months afterwards. While the numbers who actually commit suicide are small, they represent a much larger group of individuals who struggle with suicidality and the impact of their deaths can have a profound impact on all involved.

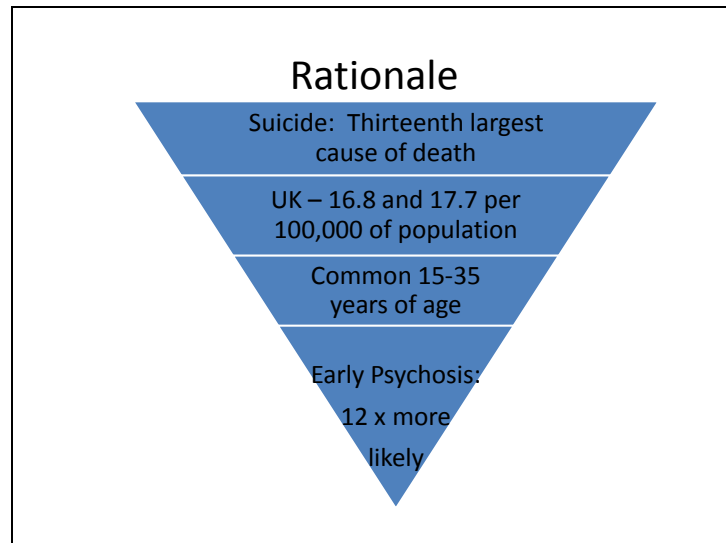


Over the next 15 minutes I will explain how this piece of research is aiming to identify the risk of suicide in people experiencing early psychosis to help with intervention. This will begin with a brief rationale of research followed by a discussion on the process that was utilised whilst recruiting this group of service users. To conclude, I will talk about the problems I encountered, the solutions that I found useful and reflect on this experience and what I have learnt.

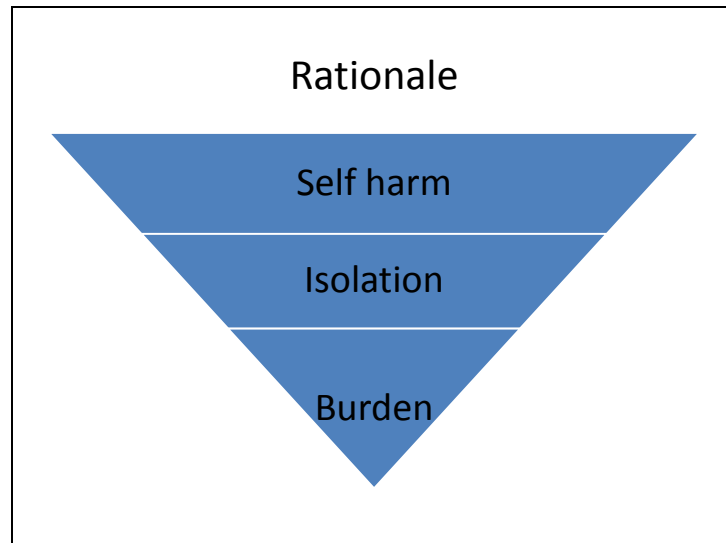
Aims

- Find out why people with early psychosis are more likely to attempt suicide
- Thomas Joiner' (2005) Interpersonal-Psychological Theory(IPT) of suicidal behaviour
- Enhance support and develop effective interventions

The aim of the study was to find out why people who had experienced early psychosis were more likely to attempt suicide compared to others using Joiners (2005) Interpersonal Psychological Theory of suicide behaviours. The study aimed to assist in enhancing support and develop effective interventions.



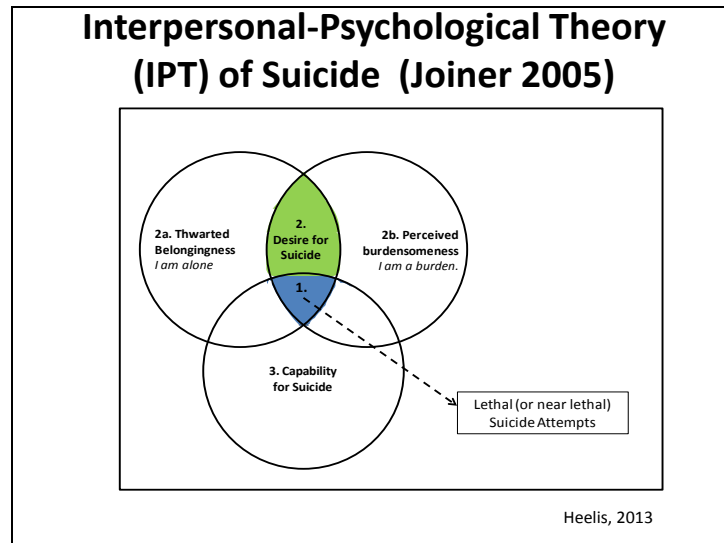
Suicide is reported to be the thirteenth largest cause of death, with approximately one million suicides each year worldwide (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). In the United Kingdom rates of suicide have been found to be ranging from 16.8 and 17.7 per 100,000, of the population (Office for National Statistics; ONS 2012), with those aged between 15-35 years of age accounting for 20% of suicide rates in the general population (Appleby Cooper & Amos, 1999). Individuals with psychosis have been found to be 12 times more likely to commit suicide (Dutta et al., 2010) with most occurring soon after the onset of psychosis (Palmer, Pankratz & Bostwick, 2005).



When investigating the factors of suicidal risk of individuals with psychosis, the strongest predictor has been found to be previous deliberate self-harm (Sakinofsky, 2000).

Additionally, loneliness, helplessness (Cohen, Test & Brown, 1990) and a lack of social support has been associated with a higher rate of suicidal attempts (Randomsky, Hass & Mann, 1999).

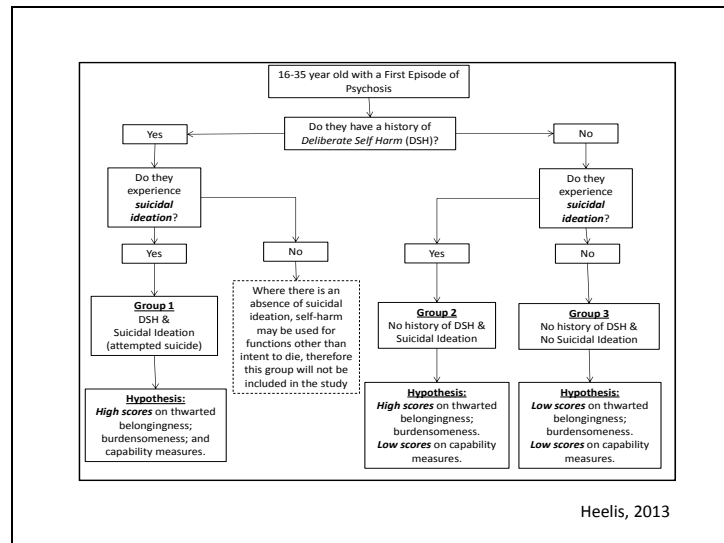
However, even with social support, some individuals have expressed a feeling of being a burden on friends and family members, with a belief that these people would be better off if they were dead (WFMH, 2014). Whilst numerous risk factors have been explored what may predict a suicide attempt, research has not offered an integrative explanation. (Prinstein, 2008) or investigated the transition between suicidal ideation and suicidal behaviour (O'Connor, 2011).



The Interpersonal Psychological Theory of Suicide (Joiner, 2005) provides an integrative approach to investigating these risk factors and suggests that the desire to commit suicide is due to a feeling of thwarted belongingness and perceived burdensomeness. This however, will only determine suicidal behaviour if there is also an acquired capability to engage in self-harmful behaviours (Van Orden, Witte, Gordon, Bender, & Joiner, 2008)

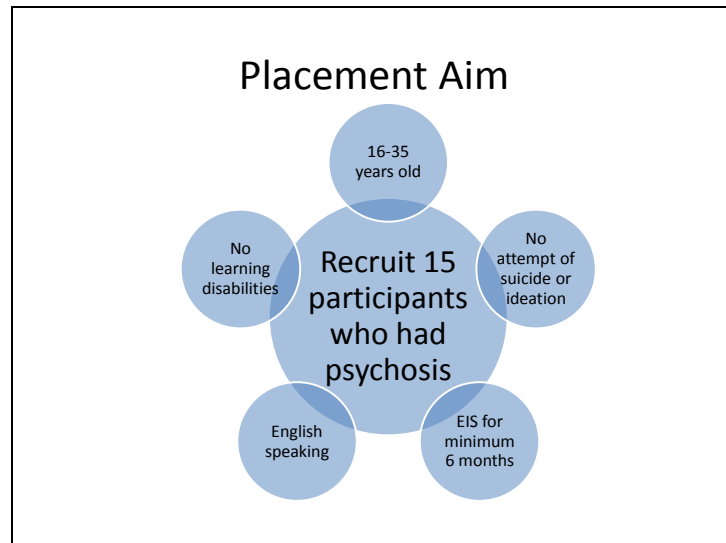
The study aimed primarily to explore if individuals with psychosis who had previously attempted suicide, had an enhanced suicidal desire to die (perceived burdensomeness and thwarted belongingness) in addition to a greater ability to do so, compared to others that had not attempted (self-harm and suicidal ideation)(number 1).

Two secondary objectives were to explore who would want to die (numbers 2a and 2b) and who could die (number 3) by suicide. This was investigated by examining whether those with psychosis that had already made an attempt of suicide, had a greater capability of future suicidal attempts compared to individuals who had no history of suicide attempts.



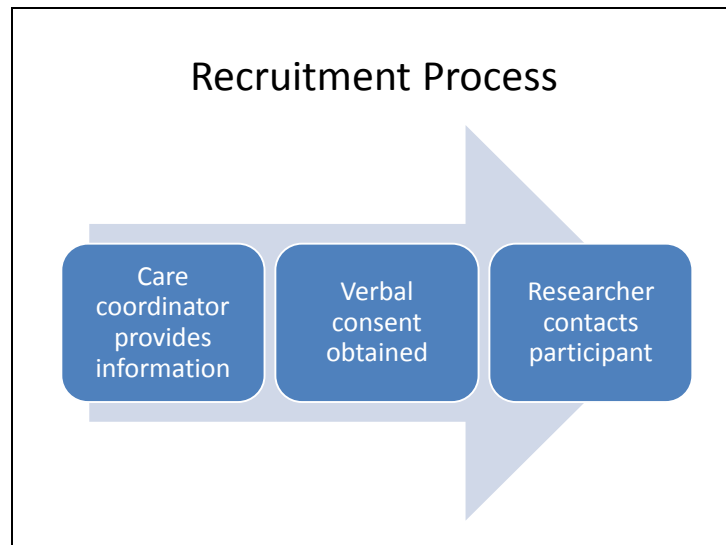
Based on the IPT, the three hypotheses being tested by the research, predicted that:

1. A high score of thwart belongingness, burdensomeness and acquired capability would be found with participants who had previously attempted suicide compared to the other two groups.
2. A high score of thwart belongingness and burdensomeness with a lower score of acquired capability would be found with participants who had experienced suicidal ideation, but no previous experience of deliberate self-harm compared to the other two groups.
3. A low score of thwart belongingness, burdensomeness and acquired capability would be found with participants with psychosis who had never attempted suicide or had experience of suicidal ideation compared to the other two groups.

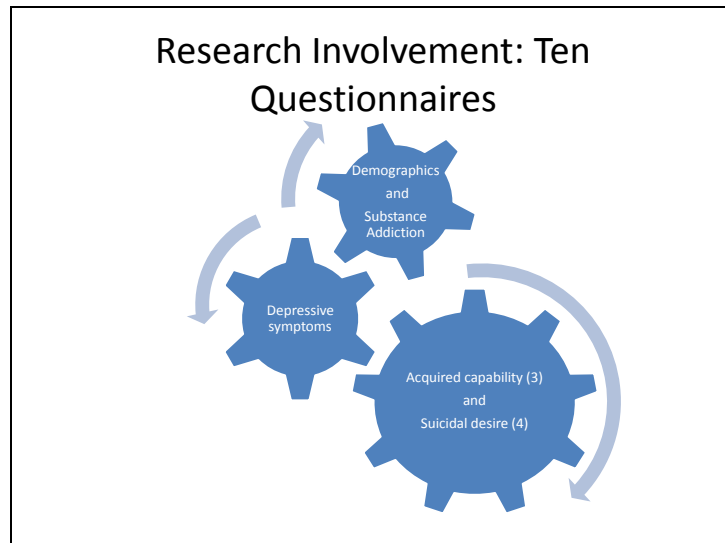


The aim of this placement was to recruit 15 young people for the control group of the research. The inclusion criterion was that these individuals had psychosis but had not attempted suicide or experienced suicidal ideation. Additionally, they were required to have been in the care of EIS for a minimum of six months and be English speaking with no learning disabilities. As this goal was completed, recruitment of participants who had attempted or had ideation was also incorporated.

Recruitment



If the inclusion criteria were met, the care coordinator provided a letter and a participant information sheet to potential participants introducing the research. If participants expressed an interest in taking part, they were contacted and invited to participate. The purpose of the research was discussed along with what would be involved when taking part and any questions or concerns were answered.



The research involved participants answering ten questionnaires that lasted approximately 1 hour to complete and was conducted in a convenient location that the individual determined. Demographics, addiction to substances and depressive symptoms experienced were all measured. Additionally, to investigate acquired capability for suicide three questionnaires were used to measure the amount of exposure in potentially dangerous situations, the frequency of exposure to painful and/or provocative experiences and the severity of suicidal behaviour and ideation. Finally, suicidal desire was measured using four questionnaires investigating interpersonal needs, satisfaction with autonomy, loneliness and reason for living.

Challenges and solutions of recruitment

- Problems with definition of suicide
 - Completed training on Columbia-Suicide Severity Rating Scale (C-SSRS)
- Over researched service user group/paid research
 - Different methods of engagement
 1. Telephone calls
 2. Visits to Lighthouse and Solihull drop in centre
 3. Psychiatrist clinic

A challenge with recruitment was trying to determine if individuals had attempted suicide, with care coordinators unsure if there was intent to die or more of a cry for help. When I reviewed the literature I recognised that this was a common problem with no psychiatric or legal definition of a ‘suicide attempt’ being universally accepted (Joiner, 2005). However, by completing the Columbia-Suicide Severity rating scale training (C-SSRS; Posner et al., 2008), I was able to determine that just the *potential* for injury was sufficient, only *some* intent to die and that both intent and behaviour must be connected which made this an easier process.

An additional challenge when recruiting from the EIS was the vast amount of research being carried out during the same period. Furthermore, larger research conducted by some organisations was offering £20 incentives. When attempting to recruit I found that visiting the weekly drop in centres and arranging with the psychiatrist to go to his clinic sessions made a more productive way of gaining participants when compared to telephone calls. Explaining to individuals face to face what the study was about enabled a good rapport to be established, with participants getting to know me prior to taking part in the research.

Challenges and solutions of recruitment

- Care coordinators large workload
 - Build rapport with care coordinators
 - Introduced myself and research at team meeting
 - Visits with care coordinator to service users
 - Attended team meetings and TDM
 - Identify potential participants to reduce workload

A further challenge for recruiting was the high volume of work the care coordinators had, short periods of time they spent in the office due to visits and only being with the service for two days a week. This created a barrier, as the research was seen as an additional aspect of their role that they were not required to perform, with this extra task occurring on a regular basis. To build a better rapport I found it useful to introduce myself and the research, in person, at the hand over meeting when all staff was present. I then asked to go on visits with individual staff members which allowed me to gain a better understanding of the challenges that they faced and displayed that I was interested in what they did in addition to what I needed from them. I attended TDM meetings and generated a list of potential participants for each care coordinator to reduce the amount of time required to identify participants. This provided a visual reminder of who they could discuss the research with when going on visits.

Challenges and solutions of recruitment

- Service users absent when visit
 - Arrange visit after 13.00
- Long period to concentrate
 - Include short breaks
 - Split session into two visits
- Recognising distress
 - Gain details of service users prior to visit

A problem that occurred was that when I went to visit service users who had agreed to participate, they were unobtainable. After speaking to the care coordinators I realised that this was due to the medication prescribed causing drowsiness and later starts to the day. I found that arranging visits after 13.00 gave me a higher success rate as participants had got out of bed and had already had their dinner.

I became aware that answering ten questionnaires over a period of one hour took a lot of concentration which some individuals found difficult to maintain. I established different ways to incorporate short breaks after various questionnaires through discussion or tea breaks.

On one of my visits, a participant displayed some excessive repetitive movements which raised my concern about how I should recognise distress when speaking to different individuals. After postponing the rest of this session, I spoke to the care coordinator who informed me that these were side effects of the medication. Following this, I ensured that I communicated with each participants' care coordinator prior to every visit about any potential side effects or triggers that I should be aware of. This allowed me to assess whether a

participant was feeling uncomfortable so that I could offer to terminate or make a return visit if required.

Reflection on placement

Reflection on placement

- Introduction to psychosis
 - Preconceptions
 - Continuum of psychosis
 - Early Intervention is key

When reflecting on this placement, this experience has introduced me to psychosis and made me aware that my own preconceptions that I had formed from the social media were incorrect. I initially believed that little could be done to help people with this condition and thought that all cases were severe. I now understand that it is on a continuum and that early intervention in the first three years can make a dramatic difference to a person's social, biological and psychological outcomes in addition to preventing further relapses (Shiers & Smith, 2010).

Reflection on placement

- Recognition of own anxiety
 - ‘Suicide’
 - Lone visiting
 - Putting ideas into individuals head
- Misplaced concern of recruitment
 - Benefits of study for control group
 - Increased confidence
 - Recognition of desire to help others

Due to my incorrect preconceptions, I was initially anxious about how service users with psychosis would react when approaching the subject of ‘suicide.’ This made me feel uncomfortable about lone visits as I was concerned that I could be putting suicidal ideas into participant’s heads. However, by reading the literature I realised that this was not the case (Smith, Poindexter & Cukrowicz, 2010) and that research related to suicide had therapeutic gain due to allowing time and space to discuss such experiences (Taylor et al., 2010).

A further concern was that I thought I may have difficulty recruiting the control group due to the aims of the research benefiting those who had attempted suicide or experienced suicidal ideation. This concern was misplaced as I was able to recruit all 15 service users for the control group. This process has increased my confidence in future research within mental health settings as I now realise that even with sensitive topics, individuals are keen to help others through their past experiences.

Reflection of placement

- Appreciate recruitment requires different strategies
 - Ideation/suicide attempt – control group
 - Mindful of wording when describing study
 - Higher decline rate
 - Providing more information – reduce anxiety
 - Option of answering questionnaires unaided

In addition to gaining confidence, this placement has increased my knowledge of some useful strategies that can be used when conducting research. As I also recruited for the attempted and suicide groups, I now realise that when explaining research, it is helpful to think about the individuals experience and adapt how you describe the study accordingly to empower the individual into having something important to express. I have also had to become more resilient to people not wanting to participate and understand that for some, reliving a difficult period of their life was not something they want to do. Attempting to recruit these individuals has made me mindful that anxiety about research is a barrier and that providing more information about what the study entails and giving the option to answer the questions unaided can reduce this.

Reflection on learning

Reflection on learning

- Appreciate dynamics of working within a team
- Experience of working within NHS policies (lone working, safe and well)
- Engagement with service users from diverse backgrounds in a variety of research environments
- Administration of ten psychometric tests (BDI)
- Greater awareness of psychosis

When reflecting on what have I learned on this placement, I now appreciate the dynamics of working within a busy NHS team. I can work within NHS policies and have enhanced my knowledge and confidence of engaging with diverse backgrounds in various research environments. I have developed skills in administering ten different psychometric tests and have a greater understanding of psychosis which I will use in my next placement.

Reflection on learning

- Intrusive questions
 - Have you been a victim/witness of sexual abuse?
- Participants sharing distressing information
 - Speak to care coordinator
 - Supervision
- Insight into application of research to facilitate evidence based practice

Additionally, I am aware that questionnaires can feel intrusive when asking private questions, so building up a good rapport is important. I now feel comfortable with how to manage participants if distressing information is shared by speaking to a care coordinator and reflecting on the experience through supervision and have gained a greater insight into the application of research to facilitate evidence based practice.

CHAPTER 3:

A QUALITATIVE STUDY TO EXPLORE THE EXPERIENCE OF PSYCHIATRIC STAFF WHO CARE FOR FREQUENT USERS OF INPATIENT SERVICES

Abstract

Background

People displaying difficulty with emotional regulation, self-harm and/or relationship problems are ‘frequent attenders’ of inpatient psychiatric units (Kessel, Lambie & Stewart, 2002). This has been reported to have a negative effect on staff attitude towards these individuals due to a sense of failure. Given that service user recovery has been associated with positive attitudes of staff (Vibha, Saddichha, & Kumar, 2008), this could potentially compromise patient care.

Aims

To explore the experiences of psychiatric staff working with people who have difficulties with relationships, emotional regulation and who may self-harm.

Method

Six qualified staff from a female inpatient psychiatric ward were interviewed for a qualitative study, with transcribed data being analysed using Interpretive Phenomenological Analysis (Smith, 1996).

Results

Three superordinate themes emerged; struggling to treat in the absence of “illness,” understanding the person behind the behaviour and the influence of control.

Conclusion

Psychiatric inpatient staff maybe at risk of compromising their own emotional wellbeing, therapeutic relationships and patient care when working to an “illness” model. Providing psychological reflective practice and formulation for hospital staff may enable a greater

understanding of the patients' needs whilst in their care. This approach can provide a structured care plan of realistic targets for outcome set and enable a more holistic approach when patients are discharged into the community.

Introduction

Psychiatric nurses are the predominant personnel working on Adult Inpatient Psychiatric Care Units, providing 24 hour care for each service user. Their job is to create and maintain a therapeutic environment for these individuals by establishing good rapport, developing trust and enhancing wellbeing (Jones, 2012).

Staff working on inpatient psychiatric units have expressed frustration when trying to support people, sometimes referred to as 'revolving door' patients (Reid et al., 1999). These individuals, also recognised more appropriately as frequent attenders, may present to services with a range of mental health difficulties, and are often re-admitted to hospital after a relatively short period in the community (Shaw, 2004). Due to the high frequency of readmission, staff perceive a positive outcome as unobtainable, with no long lasting value being observed after discharge. This has been associated with reduced staff morale, and an enhanced sense of failure and helplessness, with best efforts to increase people's time spent in the community being viewed as unsuccessful (Reid et al., 1999).

Within this group of 'frequent attenders', individuals displaying difficulty with emotional regulation, self-harm and/or relationship problems utilise inpatient psychiatric care more frequently when compared to those with other mental health difficulties (Kessel, et al., 2002). These difficulties are often labelled with a diagnosis of personality disorder (PD). However, some individuals may not have this label, but still present with the same difficulties. Whilst diagnosis for some mental health problems may provide an explanation of the difficulties

faced and help to determine treatment, for others such as those diagnosed with PD, this may not be beneficial (Lewis & Appleby, 1988). This is influenced by a current focus of psychiatric disorders being conceptualised under the same characteristics as those of physical diseases, with treatment being provided under an “illness” model of care (Moncrieff, 2010). This model implies that those who are “ill” are not responsible for their mental health problem, nor the treatment to improve their mental state. However, some diagnoses, such as PD, do not fit this model of care, with staff perceiving that these individuals are in control of their negative behaviour. The disease model blurs the distinction between the person and the disorder for these individuals (Brickman et al., 1982). Therefore for this group of patients it is not entirely clear if an “illness” driven model of care is a valid or reliable way of understanding their difficulties (Pilgrim, 2001).

Providing treatment for individuals diagnosed with PD has been recognised to be challenging with conflict and power struggles being common between patients and staff (Markham, 2003). Whilst training is provided for the treatment of diagnoses such as psychosis and anxiety disorders, this does not adequately equipped staff to work with the specific and complex needs of this patients group (El-Adl & Hassan, 2009). Staff have reported feeling inadequate, incompetent and helpless when working with individuals who display self-harm behaviour, with this not fitting into the typical “sick role” framework that they are familiar with (Fincham & Emery, 1998). Furthermore, managing these people is found to be difficult, when therapeutic care offered by staff is rejected (Nehls, 1994). This, in turn, fails to validate the therapeutic role of inpatient staff (Gallop, 1993) and reinforces a belief that these individuals are “difficult” and “manipulative” due to the perception that they do not want to improve their mental health (Gallop, 1988). Research by Kelly and May (1982) has

suggested that the label “difficult” is used when patients make staff feel ineffective or anxious and generates a negative feelings towards this patient group. This can lead to staff withdrawing from these individuals and reduce their optimism about providing effective treatment whilst in their care (Markham & Trower, 2003).

Previous literature shows that people displaying difficulty with emotional regulation, self-harm and/or relationship problems are ‘frequent attenders’ of inpatient psychiatric units (Kessel et al., 2002). This can reduce staff morale and have a negative effect on staff attitudes towards these individuals, if best efforts are perceived to be unsuccessful. As such, it is important to ask staff about their experiences of caring for people with these difficulties, and to explore how they respond to this increased demand, in order that to develop a more detailed understanding of how staff manage these challenges. This, in turn will help establish how best to support staff in their work and improve the therapeutic alliance with this patient group.

In order to develop a greater understanding of the personal experience of inpatient psychiatric staff, this study adopts an Interpretive Phenomenological Analysis (IPA; Smith, 1996) approach. This qualitative approach draws upon the fundamental principles of phenomenology, hermeneutics, and idiography (Smith, Flowers and Larkin, 2009). This enables an in-depth explorative approach to understand the meaning of the unique ‘lived experience’ of each staff member. This methodology was perceived to be suitable due to it offering insight into how psychiatric staff, whilst working on an inpatient ward would make sense of this phenomenon.

Method

Context

The research took place in a female mental health hospital which was part of the Black Country Trust NHS Foundation. This service offered support for individuals experiencing a range of acute mental health difficulties. The research arose out of a shared desire to enhance the understanding of staff's experiences of working with frequent attenders who were experiencing self-harm, suicide attempts, emotional regulation difficulties and relationship problems. The aim was to further improve the therapeutic relationship of staff with these individuals.

Design

The research employed the qualitative method of Interpretative Phenomenological Analysis (IPA) to the obtained data. Data was collected using semi-structured, 1:1 interviews.

Ethical review

Ethical approval was gained from both the University of Birmingham Ethics Committee and the NHS Research and Development Services for South Birmingham.

Recruitment

Participants were recruited from a female inpatient ward for service users experiencing mental health difficulties. An open invitation to take part in the research was offered to all qualified staff. Inclusion criteria were that nursing staff had worked with service users experiencing self-harm, suicide attempts, emotional regulation difficulties and relationship problems for a minimum of six months and were qualified members of staff. Exclusion criteria were lack of

fluency in spoken English. Six people accepted the invitation to participate. Participants were provided with a consent form and participant information sheet prior to the interview commencing. Table 1 displays the participants' information including their assigned pseudonyms.

Table 1: Participants age and time in service working on the inpatient ward

Participant	Age	Time in Service
Vici	29	1-4 years
Sam	30	10 + years
Lauren	31	5-10 years
Dianne	42	5-10 years
Helen	23	1-4 years
Danielle	52	5-10 years

Data collection

All questions were open-ended to invite participants to provide a detailed account of their experience of working with this patient group. Prior to the research, a member of the nursing staff participated in a pilot study to ensure that questions made sense, concerns were highlighted and addressed and research questions were verified to generate stimulating interview data. Participants were asked about their experience of working with females who were experiencing self-harm, suicide attempts, emotional regulation difficulties and relationship problems and were frequent attenders to the ward (see appendix 2). The following seven key areas were explored:

- Participants' positive and negative experience of working with these individuals.
- Participants' thoughts and feelings when these individuals returned back to the ward.
- Strategies that were found to be helpful/unhelpful when providing support.
- The relationship between staff and these individuals.
- The perceived experience of these individuals when admitted onto the ward.
- The outcome of a hospital visit.
- Areas where staff felt confident/less confident when supporting these individuals.

Interviews were carried out by the researcher (SB) off ward, at the NHS service where the participant's worked. The interview schedule was flexibly used as a guide only, as appropriate (Smith, Flowers & Larkin, 2009) to allow the participant's to share and reflect on their experience freely. The research interviews lasted between 30 and 65 minutes. The interviews were audio recorded, transcribed in full and anonymised by the researcher (SB) within one week of collection.

Data analysis

Standardised analytic procedures for IPA were followed set out by Smith, Flowers and Larkin (2009). The first step of the analysis involved each transcript being examined independently to ensure that focus of the analysis was on the participant. For each transcript, the recording was listened too whilst reading the transcript on multiple occasions. This enabled for each participant's voice and tone to develop a greater understanding of their experience during analysis. Initial thoughts of anything that was found to be of interest were noted down on a separate sheet of paper. Next, a detailed analysis was conducted line by line, of the descriptive aspects of the transcript. This enabled an understanding of what was seen to matter to the participant and the experience associated with readmission onto the ward.

Specific language used and conceptual comments made were noted to explore the underlying understanding of the participants account. Emergent themes were developed by establishing patterns between these exploratory notes and then formed into clusters that related to each other. This process was repeated for each interview. At each stage the analyses were triangulated by two supervisors and the researcher. The final thematic structure for these themes was collaboratively agreed between these three individuals (SB, ML and ET).

The second stage of the analysis required emergent themes across participant's to be collectively analysed to provide a description of themes present across all interviews. This enabled a rich and detailed description of nursing staffs experience of working with frequent attenders who were experiencing self-harm, suicide attempts, emotional regulation difficulties and relationship problems.

Epistemological reflections

To gain an understanding of the context in which staff worked on the inpatient ward, the researcher spent ten months working as an honorary assistant psychologist on the female ward prior to conducting the interviews. This experience may have shaped the researchers preconceptions of the research. Furthermore, the researcher was, familiar with some of the participants which may have influenced the depth of some of the questions asked and the interview technique applied. Additionally, some of the participants were aware of the researcher's psychological background which may have had some impact of their response to treatment.

Results

Although the sample was construed as homogenous their responses to working with this patient group were not homogenous. The participants experience was divided, with some staff

viewing this patient group as not being “ill” and a hospital admission being counterintuitive. In contrast, some staff perceived that these individuals did need support and that hospital was the correct place for this to be provided. Therefore, the thematic structures will begin by splitting them and seeing how there are two different ways of understanding the way staff might work with this group, but also recognising that there is one shared experience of the patient group as “being in control,” that has quite different meanings depending on how they perceive the “illness.”

Three super-ordinate themes were identified to be meaningful across the participants, with each having a sub-structure of sub-ordinate themes. These can be seen in table 2.

Table 2: Super and sub-ordinate themes emerging from the analysis of participant’s transcript of their experience of working with frequent attenders diagnosed with personality disorder

Superordinate Theme	Sub Theme
1. Struggling to treat in the absence of “illness.”	a. Proper patients are “ill” and they have no control of their behaviour. b. They are dishonest and naughty. c. They are hard to understand. d. It is weak doctors who give them too much time in hospital. e. They are difficult to work with.
2. Understanding the person behind the behaviour.	a. Recognition of difficulties faced. b. Positive outcome can be achieved when patients are in hospital. c. Working psychologically. d. Achievable outcomes.
3. The influence of control.	a. Subservient staff. b. Responsible patients.

The study design keeps an open mind about the meaningfulness of the diagnosis of personality disorder. Research participants were asked to think about a particular profile of behaviour which involved emotional dysregulation, self-harm and relationship difficulties as the main reason for repeat attendance. However, as the reader will notice, sometimes participants refer to this group of service users who are frequent attenders as people with

personality disorder. This has been highlighted because of the distinction that the reader will see in the data that follows in terms of being ill or not ill.

1. Struggling to treat in the absence of “illness” (Helen, Dianne, Lauren and Vici)

The first theme captures the initial stance of interest by displaying the ways that one sub group of nurses make sense of their encounters with frequent attenders who are diagnosed with personality disorder on an inpatient ward. This theme highlights the difficulties these members of staff experience when supporting service users with multiple admissions that are not perceived to fit well, when working to an “illness” model.

1a. Proper patients are “ill” and they have no control over their behaviour

Four of the participants expressed a distinction between “proper patients” that were perceived to be genuinely unwell compared to those that had been diagnosed with personality disorder and were seen to have control over their behaviour. For example, Helen described how she made the distinction:

To me people with psychosis - I have got a rule of thumb that people who want to be there are not unwell and people that don't want to be there are unwell and thats the same with medication. (Helen)

As illustrated by Helen, individuals diagnosed with personality disorder are believed to go against an unspoken rule that hospitalisation and medication should be a last resort - or even an unpleasant experience. Helen questions the credibility of personality disorder, and making an unfavourable moral comparison with psychosis. Dianne made the same comparison between the two diagnoses, outlining her perception of the repetitive or perseverant character of behaviour amongst individuals with personality disorder:

One individual with personality disorder constantly doing something but then we have fifteen other individuals and often it's actually the more acutely unwell i.e. people who are psychotically unwell, they get no input at all. (Dianne)

There is an implication here that, for Diane, the regularity of some behaviours indicates some degree of triviality, or attention-seeking. This is compounded by Dianne's use of the 15:1 ratio to suggest that such behaviours have a detrimental impact on "genuine patients" which is frustrating for her, strengthening the rationale for the divide between these patient groups. Dianne and three of her colleagues, find it difficult to display authority when working with this patient group due to the perception that their negative behaviour is within the patient's control. For Dianne, this behaviour is seen as manipulative of the system throughout the hospital visit. Dianne expresses her dislike for this unpleasant situation and implies that there is little that can be done other than to "put up with it" which causes a sense of frustration.

We will see these patterns of behaviour because it will get them what they want, you know the head banging on the walls, stuff like that and we know that if they come in and they want to be in hospital for a reason for a while, we know that we will have to put up with it. (Dianne)

A sense of feeling powerless in this situation is conveyed by Dianne with a perception that everything that the patient "wants" has to be provided. It is interesting that Dianne feels compelled by having no choice in her role as an inpatient nurse, when typically, in this environment the service users would be perceived to take this position. Dianne is positioned as fulfilling individuals with personality disorder "desires" rather than "needs" implying a critical, rather than sympathetic relationship to this patient group.

One thing that both Dianne and Lauren have in common is their view of patients using their behaviour to gain attention from staff. Lauren emphasises her frustration at the lack of choice that this gives her when perceiving to “have” to interact with them implying that this is not something that she wants to do. It would seem that Lauren experiences conflict between what she is “obligated” professionally to do and what she thinks should occur. A perception that these individuals are capable of taking responsibility, but are supported in avoiding responsibility, as expressed by Lauren:

They know that if they do certain behaviours they will have more than one member of staff have to come to their attention. We are all obligated to get the benefits clerk to sort that out, if they need to we can get a social worker to look at their housing so we allow them then to step back and think “OK they can do it all.” (Lauren)

There is a strong belief from all four members of staff that patients are in control of their behaviour, with this implying that individuals diagnosed with personality disorder are neither ill, nor trustworthy.

1b. They are “dishonest” and “naughty”

For many of the participants clients with personality disorder were viewed as naughty, deceitful and not to be trusted. Vici expresses disbelief and suggests that sometimes these individuals plan to “check in” to the ward like a hotel.

I know some people have come in and have planned it because they have been texting somebody on the ward and asking if there are any beds! Because the patients have told us! (Vici)

Vici goes on to suggest that some patients see the hospital as a “hotel” and she is critical of them, because she believes that this is a shameful act but they feel no shame in doing this. This highlights the polarised opinion of hospital seen by Vici, with a hospital stay being a holiday rather than for treatment or respite. This would seem to make Vici question her professionalism requiring the need to justify her negative outlook of these individuals diagnosed with personality disorder. Vici achieves this when highlighting how other patients have also recognised this situation occurring and are shocked by this.

Helen is more direct with her opinion than Vici, and openly questions individuals with personality disorders honesty. Helen speaks with authority and a belief that others might not be aware of what she knows when saying “what they would want you to think,” implying that others with less experience may be more susceptible to believe that these people are ill. Helen goes so far as to question whether the presence or absence of illness is even relevant for admission. She suggests patients have other motives for wanting to come to hospital:

I don't think you would get an honest answer to be perfectly honest. What they would want you to think is “I'm in crisis and I can't cope and that they needed to be in hospital to keep me safe.” I don't think you would hear the “My benefits are up for renewal” or “I just want to come in hospital.” (Helen)

A sense of Helen's role being more of an administration clerk rather than a nurse when working with individuals with personality disorder is displayed. This adds to the level of control that individuals have over her.

1c. They are hard to understand

Lauren is one of the four participants that openly admits to finding it difficult to understand and treat service users with multiple admissions, revealing some vulnerability when caring for

these individuals. She is keen to highlight that this is specific to this group of patients. Patients with other diagnoses are perceived to be easier to support. Lauren protects her professionalism when describing the lack of knowledge across the whole trust, suggesting that people more senior members are no more knowledgeable and that there is a need to use formulation within the trust:

I know how to deal with schizophrenia, bipolar, depression, we learn about that all the way through Uni, but with borderline personality disorder, even going back to Uni, the amount of time you learn about then is really, really, its, I mean our training was we had a lady with personality disorder come in for a day to tell us about her experience of personality disorder which wasn't the most helpful way to learn about it. So I think as a trust we don't really have formulations in place to deal with them effectively. (Lauren)

To summarise, participants advocated a team approach by providing a strong “front line,” to reduce any vulnerability. However, doctors were perceived to weaken this defence by not providing a consistent approach with the nurses.

1d. It is weak doctors who give them too much time in hospital

Four participants describe a sense of conflict between doctors and themselves when providing care. For Dianne, a sense of being overruled by the doctors is frustrating with a belief that she has more knowledge and understanding of these individuals. Dianne believes that doctors are weak when working with individuals diagnosed with personality disorder and are easily manipulated as they “give them” what they want so that they can have an easy life. Dianne describes how the doctors rewarding bad behaviour undermines her credibility:

We see a picture and work with them for 24/7 and erm we kind of see the manipulative part of people and of patients but doctors seems to just say “we’ll give them this and it will keep them quiet” but that’s not addressing their behaviour, that’s rewarding that behaviour and that’s not what we are trying to do. (Dianne)

This feature of doctors making the job more difficult for nurses is typical of the other participants with the main lack of support being seen when doctors delay discharge.

1e. They are difficult to work with

Three of the participants found it difficult and frustrating when working with this group with a sense of uncertainty being expressed of how to deal with these individuals. Lauren describes the unpredictability of treatment leading to a belief that a positive outcome is unobtainable:

For me it’s extremely difficult because you always feel like erm I don’t know what the end result will be, when you are dealing with someone with personality disorder you kind of feel like no matter what you do the outcome is never going to be positive because I think it always feels like no matter what I do, if we are discharging them today they will be back again in a couple of weeks’ time with the same sort of problems and we will be back to square one. (Lauren)

For Lauren it would seem that her best effort is not good enough when working with individuals with personality disorder, making her feel helpless in their recovery. Vici expands further on Lauren’s experience by describing how this patient group make her feel:

Sometimes when you know some patients are coming back you can get anxieties or sort of pre stresses because you know they are coming back again and you don't know how you are going to cope. (Vici)

For Vici, the difficulty of not knowing how to cope with service users with personality disorder when they are repeatedly coming into the hospital generates negative emotions. This is interesting, as it would typical be expected that this concern would be expressed by the patients themselves when coping with their mental health difficulties rather than the staff supporting these individuals. It would seem that these people, due to their uncertain outcome, make her feel uneasy and worried that she will not be able to manage their care effectively. The difficulty for Vici working with this patients group would seem to be associated with a sense of vulnerability and a lack of perceived ability to promote recovery when patients return. This experience could be seen to have an impact on her Vici's confidence, with her blaming herself for her perceived failure.

2. Understanding the person behind the behaviour (Sam and Danielle)

The second theme moves onto a group of nurses that have a slightly different view and these themes are drawn out from their data. These nurses express compassion and an understanding the individuals difficulties and point of view.

2a. Recognition of difficulties faced

Two participants expressed an awareness of the precipitating factors and an understanding of the difficulties experienced by these individuals. This awareness for Sam, displays sympathy and a need to help, describing this situation as something that causes sadness:

I feel sorry for them, yeah sorry for them because they've got a lot going for them, yep, they can't see that because of the way they are feeling at that time and they are told basically that they are not worth anything by family and I feel quite sorry for them and I want to help and try to, so it makes me quite sad. (Sam)

There is an implication here that, for Sam, understanding the person rather than the behaviour, generates a desire to provide a positive outcome for these individuals. Whilst this is not always easy to achieve, a willingness to open up to these negative emotions conveys the impression that this member of staff is confident in their own ability. Danielle compliments Sam's understanding of the difficulties faced by these individuals but this awareness helps her to see why the illness occurs and how hospitalisation can fulfil an unmet need in the community:

They can lose partners, their children might be taken into care, and if these things all come together its get very disjointed and sometimes you can understand the mental health really dropping because you know, they seem to be in some cases getting a lot of negative blows and it's their way of coping, by staying on the ward and not have to face reality. (Danielle)

The understanding that both Danielle and Sam share reveals the compassion they feel for these individuals and provides a rationale for why each individual diagnosed with personality disorder should be in their care. There is an implication here that this allows both these nurses to see the person in their own right, making it easier to see the function of their behaviour and how to intervene.

2b. Positive outcome can be achieved when patients are in hospital

Sam and Danielle share a further outlook when expressing the positive outcome that these individuals achieve when admitted to hospital. Sam describes the reasons why this environment promotes recovery:

I think they felt quite supported and safe, they trusted the staff, and they were able to control their emotions and their feelings better on the ward because they felt safe.

(Sam)

For Sam, there is a recognition of distress, with an implication that these individuals are not “safe” when living outside the hospital. For Sam, this would seem to provide justification that these people should be admitted onto the ward for some “respite” from their difficulties. Additionally, Sam identifies the importance of the role in building a positive relationship with these individuals. Danielle also acknowledges the positive outcome that occurs when describing a specific case:

There was a patient that was in here recently who we just built up their self-worth through simple communication of helping her to take her medication, just spending time with them, asking “has she took her meds?” Taking her off on her own and just doing simple little things, which you might think “for God sake, she’s a grown woman” but it helped her to get her off the ward and stay off the ward. (Danielle)

As illustrated by Danielle, these people do not require a lot of input for their difficulties to be conquered. This is compounded by Danielle’s repetition of the word “just” suggesting that a minimum amount of intervention is required to get these individuals to remain well. Danielle highlights her capability for recognising the underlying factors that these people experience. She views the enhancement of this as an important aspect of the treatment revealing a person centred approach.

2c. Working psychologically

Understanding the reason underlying the behaviour is important for both Sam and Danielle with psychology viewed as a valuable resource to gain support. Sam views this as a priority when describing the treatment of individuals diagnosed with personality disorder:

It's always good to have an input from a psychologist on the ward and looking at why they are doing what they are doing. That's one of the biggest things for people to understand really, why are they doing what they are doing? (Sam)

Danielle builds on the influence that psychology has on the ward, acknowledging the positive outcome that are achieved when trying to understand the person and the pleasure that this brings her:

Hurray! That was working with psychology, not just me, it me finding the roots and then taking it to psychology to find out how we can do this and luckily I had psychology who was on the ward that day. (Danielle)

Danielle portrays a team effort as being most effective to provide the best possible care.

There are indications from her that psychology is helpful in providing direction on how to intervene through establishing a formulation. However, Danielle highlights that this requires some initiative from her to utilise this support, suggesting a desire to work psychologically is required to utilise this knowledge.

2d. Achievable outcomes

Both Sam and Danielle overtly discuss their confidence when working with individuals with personality disorder, associating this with a greater understanding of the individual's

behaviour. Sam displays an acceptance of not being able to achieve a perfect outcome but still recognising the benefits to recovery that can be provided:

I feel confident with people with personality disorder and will spend time trying to gain a better understanding of why they are doing the things they are doing, obviously you are never going to know how they are feeling exactly but trying to gain some understanding help them to manage the feelings to try and reduce the thoughts of self-harm, aggression. (Sam)

This positive outcome, for Sam, is associated with seeing each patient in their own right and implies that this is useful for generating a formulation and psychological intervention. It would seem that using this strategy and understanding the function of the behaviour provides Sam with a protective factor of not being responsible for service users who frequently returns back to hospital.

Danielle also highlights that talking to the patients and having psychological input has enhanced her confidence and feels that this would be beneficial for all nurses in their practice:

I am a lot more confident now in dealing with it, with making sure that you keep the channel of flow going with the patient. I think there should be more training in psychology that you can work on the same guidelines. (Danielle)

By using the word “more” when talking about her confidence, Danielle expresses that this has not always been the case. She recognises this improvement from earlier on in her career but still portrays a desire to further improve and utilise psychological practice as part of her daily work routine.

3. The influence of control (3a. Lauren and Dianne) (3b. Sam and Danielle)

The final theme highlights that whilst there are two different ways of understanding the way staff might work with this patient group, there is a shared experience of the patient being in control by all six of the nursing staff.

3a. Subservient staff

Four of the participants felt that they were controlled by “these people” with this being a negative experience. Lauren, using the word “fulfilling” when describing this control, portrays that individuals with personality disorder gain satisfaction from avoiding responsibility:

If their aim is to run away from something else to avoid responsibility for something at home or because they are after us to look after them I can imagine it must be quite fulfilling in a way because they come into an environment where they have lots of staff 24/7 beck and call. (Lauren)

There are implications here that, for Lauren, having to provide support for clients with multiple admissions requires her to be subservient to requests that she perceives as inappropriate. Satisfying the need to avoid responsibility is for Lauren, a counterproductive process, with this making hospital a desirable place for which to return. This would work against her professional objective of preparing individuals to remain in the community and threaten her own identity as a nurse.

Dianne also talks about being controlled by individuals with personality disorder but provides a more specific description of how this is achieved through the use of behaviour:

“I’ll self-harm so you will put me on a one to one because I want someone with me.”
If you have people who you know are constantly tying ligatures or you know they are
on a one to one are fine but then as soon as you reduce their observation they then
start self-harming again. (Dianne)

As illustrated by Dianne, individuals with personality disorder are believed to use self-harm to manipulate staff into providing them with a level of care that is unnecessary. Dianne questions the credibility of self-harm and indicates the predictability of this behaviour, strengthening her rationale that this is attention seeking behaviour.

3b. Responsible patients

In contrast, two of the participants view patients being in control as a positive aspect for their recovery with them being able to work with their capabilities to help their mental difficulties improve. For example, Sam describes how these patients take responsibility of their own mental health difficulties once provided with the relevant skills:

Giving the patients skills to manage their own emotions, their feelings, their thoughts
they are having at the time. (Sam)

There are implications here, that for Sam, empowering individuals with personality disorder to be in control of their own recovery fulfils a professional role as a nurse and provides a clear treatment plan to adhere too. By doing this, Sam is able to observe the positive outcome that service users with multiple admissions make whilst in hospital, but also accept that once discharged, the responsibility of remaining well lies with the patient. Danielle also expresses the importance of these individuals with personality disorder taking control of their own recovery, but for her this is something that has to be nurtured. Danielle describes this:

You don't want someone to get too needy so obviously they have got to become independent in their own right because the independence promotes their positivity for recovery. (Danielle)

Danielle recognises that individuals with personality disorder can become “needy” of her support, but accepts this as part of their “illness”. For both Danielle and Sam, promoting independence to support patients to gain control over their “illness” requires a collaborative approach. This would be seen to alleviate any power struggle and instead enable a therapeutic process that both perceive to bring about positive change.

Discussion

The analysis identified three related themes. The first theme ‘*struggling to treat in the absence of “illness”*’ displayed the difficulties that some staff experienced when supporting frequent attenders, diagnosed with personality disorder, who did not fit well when working to an “illness” model of care. The second theme ‘*Understanding the person behind the behaviour*’ showed that participants who understood the service user’s difficulties and point of view were more confident in their role and compassionate to the individual’s needs. The final theme ‘*The influence of control*’ highlighted that whilst there were two ways of understanding the way staff might work with this patient group, there was a shared difference of the patient being in control.

The staff experience of working with these individuals differed between the two groups of staff. Nurses who viewed this patient group as having the capacity and capability to help themselves in their own recovery were seen to cope well, working collaboratively with these individuals. Nurses who felt that the capability of this patient group was counterintuitive to them providing support in a hospital environment were found to struggle with meeting the

emotional needs of these as individuals. Understanding the point of view of the staff that are struggling when supporting these individuals may provide us with a greater sense of why this divide occurs and help to recognise potential ways to improve this relationship.

Struggling to treat in the absence of “illness”

The attribution theory (Heider, 1958) could help explain why some members of staff have difficulties when supporting these individuals when perceiving this patient group to be in control of their own negative behaviour. This theory is based on the idea that people determine the cause for events so that they can experience a sense of control in their environment (Kelly, 1971). This is broken down into four dimensions; 1. Internal verses external causes of an event; 2. The extent that the cause of the event is stable or unstable, and whether it remains the same each time it occurs; 3. Global verses specific is the cause of the event having an influence on other events; 4. The extent that the person is perceived to be in control or not in control of the event or behaviour.

This patient group has been found to elicit negative responses from hospital staff due to a perception of negative behaviour being more stable, with both the causes of the behaviour and the behaviour itself being in the control of the patient (Markham & Trower, 2003). This has been recognised to reduce sympathy (Dagnan, Trower & Smith, 1998) and the belief that change is possible (Markham & Trower, 2003), viewing these individuals as “difficult” to work with (Rabkin, 1974). This labelling of “difficult” has been linked to staff feeling ineffective and anxious in their role due to this patient group working against their best efforts. Furthermore, when staff perceive that recovery cannot occur, staff lose their faith in their ability with this leading to a sense of helplessness (Main, 1957). This generates an impervious response from staff to compensate for their feeling of ineffectiveness (Gallop,

1985). This impervious response implies that staff have a hidden knowledge that this patient group are unaware of, enhancing a sense of control when interacting with these individuals.

The perception of four of the participants (Helen, Dianne, Lauren and Vici), that this patient group are perceived to be in control of their behaviour also means that they do not meet the criteria of working within a predominantly utilised "illness" model. Working within this model, the causes of illness is viewed as an external force, with treatment being available and recovery possible (Moncrieff, 2010). This may makes it more difficult for staff to support patients with these difficulties, as they do not have an understanding of what treatment to provide and perceive that recovery is not possible. Additionally, this model, viewing the origin of illness due to external factors, involves the questioning of who is deserving of treatment and who is to blame. This could have implications for staff's willingness to help, (Brickman et al., 1982) with these individuals being seen to have desires to be met rather than medical needs that require treatment. This perception could put the nurse in a critical relationship of distrusting the patient rather than being sympathetic to their needs (Markham & Trower, 2003). This distinction is highlighted between the two groups of staff when looking at what a hospital representing; a "hotel" compared to a place for "respite." For some staff, hospital is perceived as a place that patients choose to visit with the implication that this is viewed as a holiday. Doctors who delay the discharge of leaving the "hotel" are viewed as weak and making the nurses job more difficult. In comparison, for patients that come into hospital for "respite" or "safety," hospital is not seen as luxurious, but a supportive environment where structure is provided to enable space for recovery. The perception of "illness" when working within this model is making it difficult for some members of staff. It would seem that the training that they receive under this model is not found to be successful

when supporting this patient group. This makes it challenging for staff to feel confident in providing the level of care they strive to deliver with these individuals.

The perception that patients choose to come into hospital and have control over their behaviour disempowers some staff and makes them feel that there is nothing they “can” do and are compelled to treat these individuals. This is an interesting inversion as this environment would be typically seen to take away the choice of treatment for service users who are finding it difficult to cope. It could be that working within an “illness” model obscures the values of judgement, due to a diagnosis being provided (Moncrieff, 2010). By conceptualising diagnosis for mental illness in the same way as a medical disease, this model would imply that the outcome of the difficulty is determined by the cause of the disease (Moncrieff, 2010). Whilst this could be beneficial for those patients who fit this model, with neither illness nor treatment being the individual’s responsibility, it would also indicate that those viewed as responsible for their behaviour should also be responsible for the solution. Staff could therefore view patients diagnosed with personality disorder as failing to put in the effort in for their own recovery to progress (Brickman et al., 1982), which in turn, could reduce their compassion and belief that these individuals are really “ill” and so don’t require staffs’ support to become more well.

Understanding the person behind the behaviour

One of the key differences between the two groups of staff is the perception of “illness.” Staff that understand the person behind the diagnosis see the individual as trustworthy and deserving of treatment and compassion. By not focusing on the disease, these staff don’t see the individual as unfixable or having symptoms that are unexplainable. Instead, they focus in on the whole person and how they can create the conditions to support each person in their

own recovery (Cole-King & Gilbert, 2011). This outlook takes away the blame and instead makes each patient deserving of hospitalisation and care. This could display why greater confidence and positive perception of recovery is experienced by this group of nurses, with compassionate care improving clinical outcome and lowering levels of burnout (Cole-King & Gilbert, 2011).

The influence of control

The staff experience of the first group of participants displays that they are being manipulated by people who they perceive to be in control of their behaviour and not “ill”. This is in contrast to the second group of participants who believe that they can work with these capabilities and get people feeling more well and back into the community. These two different perspectives of control shape the experiences of these two groups. For group one, a feeling of frustration is revealed, with the situation being something that they believe cannot be influenced or controlled. These negative feelings may undermine compassion, reduce morale and make staff turn away from this patient group (Cole-King & Gilbert, 2011), explaining the feeling of “helplessness” portrayed throughout the interviews. Whilst this group of staff have good intentions, their feeling of “helplessness” could be reduced by enhancing their knowledge and understanding of how to support these individuals.

Participants in group two show an understanding of the factors associated with the service users’ difficulties and the mechanisms that maintain these. The psychological input that these participants seek out, would be seen to provide them with a more exploratory account of the individual’s difficulties when compared to working within an “illness” model. Kinderman (2005) suggests that this understanding helps staff to change their perception of “illness” and enhances compassion associated with positive outcomes. This approach would make sense of

the complexity of mental illness and reduce any moral judgement of control and whether treatment is deserved, providing compassion to all service users regardless of what diagnosis they have attracted.

Clinical implications

The key findings identified that the difficulties some staff experienced were due to them blaming patients, with their perception of patients' negative behaviour being controllable, making them feel "helpless" in their role. In contrast, members of staff who had a psychological understanding of the person behind the behaviour felt better able to cope with this patient group.

The research finding would suggest that working with this patient group makes some staff feel vulnerable, ineffective in their role and generates conflict with doctors on the ward. Utilising regular reflective practice on an acute inpatient ward could be beneficial, with this encouraging the whole multi-disciplinary team to discuss difficult cases, critically analysis and evaluate current daily practice and help to generate new ways of working (Bolton, 2010). This forum would allow staff to manage their own emotional wellbeing and improve group dynamics (Lown & Manning, 2010), reducing the conflict experienced between nursing staff and doctors through a more collaborative approach. Furthermore, reflective practice could help to contain staff anxiety generated from uncertainty and improve the therapeutic relationship by allowing staff to gain greater insight (Cole-King & Gilbert 2011). This could have a positive impact of patient outcome with enhanced therapeutic relationships being recognised as a key factor in facilitating change (Lambert & Ogles, 2004).

The use of psychological formulation on the inpatient ward could also be incorporated into reflective practice sessions and be useful to assist in the development of a more psychological

and holistic approach when supporting patients (Kinderman, 2005). By understanding the factors underlying the service users' difficulties and how these are maintained, staff perception of the "illness" could be changed, which in turn, could enhance confidence, compassion and help staff to adopt a recovery model (Hanna, 2008). Formulation could provide staff with an individualised care plan of what needs to be different for each person before they are discharged and how they can achieve this (Wainwright & Bergin, 2010). This could be protective for staff, by empowering them to gain an understanding of effective therapeutic interventions that can enable the patient to take responsibility for their own mental wellbeing (Durrant, Clarke, Tolland & Wilson, 2007). This could reduce the perception of failure some staff experience when patients frequently attend by promoting a clear rationale for what care they should be providing, why this is and what realistic outcome staff should be working too. This psychological formulation could then be passed over to community team to ensure a more holistic approach throughout the health service.

Limitations

The analysis outlined the experience of six psychiatric nurses working on a female inpatient ward. However, by utilising an idiographic, rather than a nomothetic approach these results are not directly generalisable to other inpatient settings. Nevertheless, by understanding the difficulties experienced by some psychiatric staff, suggestions that could provide support for healthcare professionals have been highlighted.

Whilst purposive sampling was utilised, participants volunteered to take part in the research. During the recruitment process, some staff supported some particularly challenging individuals. This may have influenced their willingness to participate, with a desire to talk about this experience providing a more negative account, potentially skewing the sample.

However, differing accounts from staff were expressed, suggesting that both positive and negative experiences were recruited and captured. It should also be acknowledged that whilst the recommendations of psychological input would be seen to be beneficial, as the researcher was training to be a psychologist, this could be seen to shape a psychological way of thinking. Nevertheless, a research diary was completed throughout the process and any concerns were discussed through clinical supervision to try and reduce researcher bias.

Conclusion

Some psychiatric inpatient staff, when working to an “illness” model of care, find it particularly difficult supporting individuals, who are not perceived to meet this criteria, experiencing frustration, helplessness and failure when these people are readmitted to hospital. By providing psychological reflective practice and formulation, a greater understanding of the individuals needs can be ascertained, a structured care plan put in place and realistic targets for outcome set. This would provide a more holistic approach both within inpatient care and when service users are discharged into the community. It could be advantageous for futures research to investigate which models of psychological formulation are found to be most helpful for staff and whether these vary according to the specific patient group, e.g. mentalisation could be a useful method for this patient group whereas CBT may facilitate a greater understanding of anxiety.

APPENDICES

Appendix 1: Quality assessment questions and ratings

		Kessel	Vasudeva	Lang	Wickizer	Juven Weltzer	DeGroot	Kemp	Ho-Wan Chan	Dilonardo	Petrie	Stewart	Thambyrajah	Appleby
	Assessment questions	Yes (2), Partial (1), No (0), N/A												
1	Question/objective sufficiently described?	2	2	2	2	2	2	2	2	2	2	2	2	2
2	Study design evident and appropriate?	1	2	2	2	2	1	1	2	2	1	2	2	2
3	Method of subject/comparison group selection or source of information/input variables described ad appropriate?	2	1	2	1	2	2	2	2	2	1	2	1	1
4	Subject (and comparison group if appropriate) characteristics sufficiently described?	2	1	2	2	2	1	2	2	2	2	2	2	2
5	If interventional and random allocation was possible, was it described?	N/A	N/A	N/A	N/A	N/A	N/A	1	2	1	N/A	N/A	N/A	N/A
6	If interventional and blinding of investigators was possible, was reported?	0	0	0	0	0	2	2	0	0	0	2	0	0
7	If interventional and blinding of subjects was possible, was reported?	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/misclassification bias? Means of assessment reported	1	1	1	2	2	2	2	2	2	2	2	1	1
9	Sample size appropriate?	0	2	1	2	1	0	1	1	1	1	2	2	2
10	Analytic methods described/justified and appropriate?	2	2	2	2	2	2	2	2	2	2	2	0	2
11	Some estimate of variance is reported for the main results?	2	2	2	2	2	2	2	2	2	2	2	1	2
12	Controlled for confounding?	2	2	0	2	1	1		2	2	1	2	2	1
13	Results reported in sufficient detail?	2	2	2	2	2	2	2	2	2	2	2	2	2
14	Conclusions supported by the results?	2	2	2	2	2	2	2	2	2	2	2	2	2
		18	19	18	21	20	19	21	23	22	18	24	17	19

Appendix 2: Interview schedule

1, What do you understand by the description ‘revolving door patient?’

Could you describe an example for me please?

2, Can you tell me what kinds of patient typically fall into those categories, what are the presenting problems you encounter, what sort of issues do you have to work around with that patient group?

3, What is it like to work with someone who has been diagnosed with BPD and is a revolving door patient?

Difficulties/ positive experiences

4, Typically, what are the circumstances when ‘revolving door patients’ are admitted to the ward?

5, How do you feel when you see these individuals returning to the ward

6, What do you find helpful when supporting these individuals who are frequently in hospital?

Why does this help with care?

7, What do you find unhelpful when supporting these individuals who are frequently in hospital?

Why does this not help with care?

Contributes

8, What are the relationships like between staff and patients who are revolving door?

Does this differ from patients who are new admissions?

9, What is your understanding of what these individuals hope to gain when they are admitted to hospital?

Are there any barriers that hinder this?

10, What do you think it is like for these patients while they are in hospital?

11, What do you think the patients value and want from their time in hospital?

12, What kind of contact do you think patients would like with staff?

Do you feel these needs are able to be met by staff?

How does this affect your role on the ward?

13, What changes would you expect to happen by the time these individuals are ready for discharge?

Prevention

14, Where are the areas that you would feel most confident in your work with these individuals?

15, Where do you feel less confident in your work and what kind of things would be helpful with the areas that you would like to develop more knowledge, skills or have different resources?

16, If you could re-design one aspect of your role to further improve support for these what would be the area that would make the most positive impact?

12, What support could help you achieve this?

Any questions?

Thank you.

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